

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

COUNTY **Montgomery** MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) **Bethesda Rural**
 LENGTH OF STAY (in this place) **14 days**

HOSPITAL OR INSTITUTION OR STREET ADDRESS **U. S. Naval Hospital**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **District of Columbia**
 COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Washington, D.C.**

STREET ADDRESS (If rural give location) **4200 Cathedral Avenue, N. W.**

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Arban**Jay****ACKERMAN**

4. DATE (Month) (Day) (Year)

OF DEATH:

January 12**1956**

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Single

8. DATE OF BIRTH:

8-22-04

9. AGE last birthday

51 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Architect

10B. KIND OF BUSINESS OR INDUSTRY:

Industrial

11. BIRTHPLACE (State or foreign country):

Tennessee

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME:

Arban ACKERMAN

14. MOTHER'S MAIDEN NAME:

Cary KEMP

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unk.) (If Yes, give year or dates of service)

Yes**WW II**

16. SOCIAL SECURITY NO.

085-07-2718

17. INFORMANT'S ADDRESS:

**Sister Mrs. Vivian SWANSON
Same as above**

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE

(A)

Pulmonary Edema

INTERVAL BETWEEN ONSET AND DEATH

Terminal

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.

(B)

Arteriosclerotic Heart disease**Unknown**

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

C.A. Tongue**7 mo**

19A. DATE OF OPERATION:

1/11/56

19B. MAJOR FINDINGS OF OPERATION

C.A. Tongue, Tonsil, Palate, Soft, Right tracheal metastasis

20. AUTOPSY?

YES ☒NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **28 Dec**, 19**55**, to **12 Jan**, 19**56**, that I last saw the deceasedalive on **12 Jan**, 19**56**, and that death occurred at **1513**

M, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

R. L. KING **CDR MC USN U. S. Naval Hospital, NNMC, Bethesda, Maryland**

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

17 Jan 1956

NAME OF CEMETERY OR CREMATORY

Forest Hill Cemetery

LOCATION (City, town, or county)

Memphis, Tennessee

(State)

DATE REC'D BY LOCAL REGISTRAR

13 Jan 1956

REGISTRAR'S SIGNATURE

Mary C. Parrelly

24. FUNERAL DIRECTOR

R. A. Pumphrey Funeral Home

ADDRESS

7557 Wisconsin Avenue, Bethesda, Md.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 16 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>District of Columbia</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Washington</u>			
TOWN <u>Bethesda</u> LENGTH OF STAY (in this place) <u>100 days</u>				TOWN <u>Washington</u> 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Maryland</u>				STREET ADDRESS (If rural give location) <u>1103 - 9th Street, N. W. Apt. 2</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Iola</u> (Middle) <u>Burnett</u> (Last) <u>Adams</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 22, 1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH: <u>March 27, 1904</u>	9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>	11. BIRTHPLACE (State or foreign country): <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>James W. Adams</u>				14. MOTHER'S MAIDEN NAME: <u>Cordelia Cozzen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hepatic Coma</u>						days	
ANTECEDENT CAUSE (S) DUE TO <u>Carcinoma of R. breast</u>						9+ mos.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>3 11-9</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Hepatic metastases; Morrison pouch metastases</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 14 1955</u> , to <u>Jan. 22 1956</u> , that I last saw the deceased alive on <u>Jan. 22, 1956</u> , and that death occurred at <u>9:03 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert Austin Mill</u>		ADDRESS <u>M. D. The Clinical Center, NIH, Bethesda, Md.</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-28-56</u>		NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem. Cem.</u>		LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-23/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>R. E. Jarvis</u>		ADDRESS <u>1432 Youn. H. E.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 25 1956

RECEIVED

U.S. Bureau of Investigation
143-444-15

CERTIFICATE OF DEATH

Reg. Dist. No. 216.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Md.	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10707 Shaftsbury Street		STREET ADDRESS (If rural give location) 10707 Shaftsbury Street	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
Genevieve Ambush		Jan. 27, 1956	
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Feb. 16, 1894
		9. AGE last birthday: 61 yrs.	IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY:	
		Barnesville, Md.	
13. FATHER'S NAME: Charles E. Claggett		14. MOTHER'S MAIDEN NAME: Edmonia Ambush	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: Wm. T. Ambush 10707 Shasberry Street	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) Congestive Heart Failure		1 month
ANTECEDENT CAUSE (B) Carcinoma Breast (Right)		6 months
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		4 yrs.
(C) Arteriosclerosis generalized		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: April 29/55	19B. MAJOR FINDINGS OF OPERATION: C. of Breast - Rt. + Benign Metastasis generalized	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **1953**, 19....., to **1/27**, 19**1956**, that I last saw the deceased alive on **1/26**, 19**1956**, and that death occurred at **12** M, from the causes and on the date stated above.

SIGNATURE [Signature]	DATE SIGNED 10 A.M.
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 1/31/56
NAME OF CEMETERY OR CREMATORY Fairview Cemetery	LOCATION (City, town, or county) (State) Frederick, Md.

DATE REC'D BY LOCAL REGISTRAR 1-30-56	REGISTRAR'S SIGNATURE Bessie M. Thompson	24. FUNERAL DIRECTOR John T. Stewart	ADDRESS 30 H Street, N.E.
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RECEIVED

FEB 2 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00700

Reg. Dist. No. 217

Iter 7, Fil-9192 2-7-56 et

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Derwood</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sandy Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Melinda Russell's Nursing Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u> (Middle) <u>H.</u> (Last) <u>Awkward</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>January 29 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1/25/89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>67</u> yrs. If under 1 year Months Days Hours Min.
13. FATHER'S NAME <u>Presley Awkward</u>		14. MOTHER'S MAIDEN NAME <u>Lavinia Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Emily Thomas, Sandy Spring, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

154X
Immediate cause

(a) Secondary Anemia

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma Prostate

(c) None

INTERVAL BETWEEN ONSET AND DEATH

3 mos

1 year

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office hldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒

22. I hereby certify that I attended the deceased from 12/10, 1953, to 1/29, 1956, that I last saw the deceased

alive on 1/24, 1956, and that death occurred at 11/29 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-31-56

Arturde B. Lawby

Robert L. Snowden

Road

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 3 1956

BUREAU V. B.

747 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00701
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rt. #2 Germantown</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Charles William Barton</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>1 16 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>11-21-02</u>
9. AGE last birthday <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>		13. FATHER'S NAME: <u>Joseph Barton</u>	
14. MOTHER'S MAIDEN NAME: <u>Fitzwater, C. F.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Fitzwater, C. F. - Germantown, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>			<u>1 day</u>
ANTECEDENT CAUSE (S) (B) <u>Bronchitis & pulmonary fibrosis</u>			<u>? years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Pulmonary Tuberculosis arrested</u>			<u>? years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>16 Jan., 1956</u> , to <u>17 Jan., 1956</u> , that I last saw the deceased alive on <u>16 Jan., 1956</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>17 Jan 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Wakeman Grove Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/18/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Hornbrook</u>	
24. FUNERAL DIRECTOR <u>V. L. Dellinger</u>		ADDRESS <u>Woodstock Va.</u>	

BUREAU V. S.

JAN 20 1956

RECEIVED

737 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 00702

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>D. C.</u>	COUNTY
CITY (If outside corporate limits, write and give nearest town) <u>26</u> TOWN <u>Rockville</u>	LENGTH OF STAY (in this place) <u>21</u> days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u> <u>476-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90</u> <u>Brightview San.</u>		STREET ADDRESS (If rural give location) <u>3909</u> <u>Huntington St. N.W.</u> ✓	

3. NAME OF DECEASED:			4. DATE (Month) (Day) (Year)		
(First)	(Middle)	(Last)	OF DEATH:	Jan.	24 19 56
(Type or Print) <u>FRANK Bradley BELL</u>					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days Hours Min.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>7-10-1864</u>	<u>91</u>	<u>6</u> <u>14</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Ret. Acct.</u>			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
				<u>Virginia</u>	<u>USA</u>
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>Cornelius J. Bell</u>			<u>Susan Bradley</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	17. INFORMANT & ADDRESS:		
<u>No</u> <u>No</u>		<u>None</u>	<u>Daughter Mrs. E.R. Clark</u>		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>		<u>3 days</u>
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Emaciation</u>		<u>4 mo.</u>
(C) <u>Senility</u>		<u>1 yr.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Prostatic obstruction with indwelling catheter</u>		<u>2 1/2 yrs.</u>
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>none</u>		

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>June 1, 1953</u> to <u>Jan 24, 56</u> , that I last saw the deceased alive on <u>Jan 23, 1956</u> , and that death occurred at <u>7:55 P.M.</u> from the causes and on the date stated above.		
SIGNATURE <u>Dr. H. Richwine</u>		DATE SIGNED <u>24 Jan 1956</u>
M. D. <u>5521 Western Ave</u>		ADDRESS <u>St. Mary's</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>Jan. 27-56</u>	<u>St. Mary's</u>
LOCATION (City, town, or county) (State)		
<u>Rockville Md.</u>		
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
<u>1/25/56</u>	<u>Laurel H. Kingdorp</u>	<u>Robert A. Humphrey Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 27 1956

RECEIVED

Prostate examination with catheter
showing
Prostate enlargement
4/10/56
1/10/56

Prostate enlargement

Prostate enlargement

CERTIFICATE OF DEATH

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Montgomery	STATE	District of Columbia
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Bethesda Rural	CITY (If outside corporate limits, write RURAL and give nearest town)	Washington, D.C.
LENGTH OF STAY (in this place)	6 days	STREET ADDRESS (If rural give location)	1731 New Hampshire Avenue, N.W.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	U. S. Naval Hospital		

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)	Raymond Edward BELL	OF DEATH:	January 22 19 56
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Male	White	Married	11-28-83
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
72 yrs.		Months	Days

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Engineering	Management	Conn.	US

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
George C. BELL	Mary E. HURBULT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
Yes	Unknown	Wife Mrs. Dalah R. BELL
(If Yes, give year of dates of service)		Same as above

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)		Immediate
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		Immediate
(B)		
(C)		7 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		3 yrs

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 16 Jan, 19 56, to 22 Jan, 19 56, that I last saw the deceased alive on 22 Jan 19 56, and that death occurred at 11:30P M, from the causes and on the date stated above.

SIGNATURE *B. S. Yurick* ADDRESS DATE SIGNED

B. S. YURICK, JR., MD USN U. S. Naval Hospital, NMC, Bethesda, Maryland	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF
Cremation	25 Jan 1956
NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Cedar Hill Crematroy	Suitland, Maryland

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
24 Jan 1956	<i>Mary E. Ganssely</i>	Chambers Funeral Home	3072 M Street, N.W. Washington, D.C.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 27 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

743 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00704

CERTIFICATE OF DEATH

Reg. Dist. No. 213

Item 8, Film 192 1-31-56 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE California		COUNTY San Diego	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 9 mos; 16 dys		CITY (If outside corporate limits, write RURAL and give nearest town) La Jolla			
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, NNM, Bethesda, Maryland				STREET ADDRESS (If rural give location) 6725 Muirlands Drive			
3. NAME OF DECEASED: (First) Willis (Middle) Henry (Last) BELTZ				4. DATE (Month) (Day) (Year) OF DEATH: January 17, 1956			
5. SEX: Male	6. COLOR OR RACE: Caucasian	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 21 JAN 1897 1898	9. AGE last birthday 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner		10B. KIND OF BUSINESS OR INDUSTRY: Mariner		11. BIRTHPLACE (State or foreign country): Illinois		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Jewremiah BELTZ				14. MOTHER'S MAIDEN NAME: Mary SHAFER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give year or date of service) WWI, 11, Kor		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Mrs. Twilla C. BELTZ (Wife), 6725 Muirlands Dr., La Jolla, Calif.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Adenocarcinoma, sigmoid						1 1/2 yrs	
ANTECEDENT CAUSE (B) 3 metastases							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1 April, 55 , to 17 Jan, 56 , that I last saw the deceased alive on 17 Jan, 1956 , and that death occurred at 8:20p M. from the causes and on the date stated above.							
SIGNATURE E. J. RUPNIK				ADDRESS		DATE SIGNED	
LCDR E. J. RUPNIK, MC USNR, USNH, NNM, Bethesda, Md.				18 January 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		20 Jan 1956		Arlington National Cemetery		Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
18 Jan 1956		Mary E. Casella		B. A. Pulmonery Funeral Home		7557 Wisconsin Avenue, Bethesda, Md.	

BUREAU V. S.

JAN 24 1932

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md. LENGTH OF STAY (in this place) D.O.A.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Washington Sanitarium + Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 1113 Lancaster Rd. T. Park, Md. 17

STREET ADDRESS

TAKOMA PARK,

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Mason Herbert Black

4. DATE (Month) (Day) (Year)

OF

DEATH:

1 - 181956

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday 53 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME:

Herbert W. Black

14. MOTHER'S MAIDEN NAME:

Flora Cross

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: 1113 Lancaster Rd.Mrs. Edith H. Black Takoma Park, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE

(A)

Acute Coronary Thrombosis

DUE TO

ANTECEDENT CAUSE (S)

(B)

Coronary Heart Disease

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

INTERVAL BETWEEN ONSET AND DEATH

30 min.8 years.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) (County) (State)

INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1955, to 18 JAN. 1956, that I last saw the deceasedalive on Dec. 1955, and that death occurred at 8:45 M, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

Takoma Park 18 JAN 1956

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNDAL DIRECTOR

ADDRESS

Jan. 20, 1956 Rock Creek Cemetery Washington D.C.
Jan. 18 1956 J. H. Todd 254 Carroll St. N.W. Takoma Park 12, D.C.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Coroner, Montgomery County Ratified
and permission granted for me to issue
this certificate

A. B. Ruller

BUREAU V. S.

JAN 23 1911

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bethesda</u>				TOWN <u>Washington</u> 47X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural, give location) <u>3725 Malomb NW</u>			
3. NAME OF DECEASED: (Type or Print) <u>Julia Blitsstein</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>JAN. 9 1956</u>			
5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>JAN. 17, 1890</u>	9. AGE last birthday: <u>65</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>Dist. of Columbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Jacob Dreisonstok</u>				14. MOTHER'S MAIDEN NAME: <u>Gannie Young</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Miss Jeanette Blitsstein - 3725 Malomb NW, Wash. D.C.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Carcinoma colon</u>		
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1955, to Jan. 9, 1956, that I last saw the deceased alive on Jan. 9, 1956, and that death occurred at 4:00 P. M. from the causes and on the date stated above.

SIGNATURE <u>Joseph Kinnick</u>	ADDRESS <u>6450 Wisconsin Ave, Bethesda, Md.</u>	DATE SIGNED <u>1/9/56</u>
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/11/56</u>	NAME OF CEMETERY OR CREMATORY <u>Washington Hebrew Congregational Wash. D.C.</u>
LOCATION (City, town, or county) (State)	24. FUNERAL DIRECTOR <u>SH. Hines Co</u>	ADDRESS <u>2901-14th St. NW. Wash. D.C.</u>
DATE REC'D BY LOCAL REGISTRAR <u>1/10/56</u>	REGISTRAR'S SIGNATURE <u>Bonnie M. Thompson</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 12 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Olney</u>		<u>1 day</u>		<u>Clarksville</u> <u>13X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Montgomery County General, Inc.</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Henrietta Katherine Boardley</u>				<u>January 5 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Fe</u>	<u>Negro</u>	<u>married</u>	<u>February 2, 1901</u>	<u>54 yrs.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>				<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Henson Dorsey</u>				<u>Inez Gardner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no.</u>				<u>Hospital records</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral Accident</u>						<u>24 hours.</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/4/</u> , 19 <u>56</u> to <u>1/5/</u> , 19 <u>56</u> that I last saw the deceased alive on <u>1/5/56</u> , 19 <u>56</u> , and that death occurred at <u>4:25P</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>C. Wintakes, M.D.</u>		<u>Clarksville, Md.</u>		<u>1/7/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>1/8/56</u>		<u>Locust Grove</u>		<u>Simpsonville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-7-56</u>		<u>Gertrude B. Lawler</u>		<u>F. C. Hengemboerham</u>		<u>Ellicott City</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 10 1950

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 217

752

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>Olney</u>				<u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County Gen., Inc.</u>				STREET ADDRESS (If rural give location) <u>Rt. #2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Bert Louis Bolden</u>				<u>1 14 19 56</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>W.</u>	<u>widowed</u>	<u>12/28/76</u>	<u>79 7/8</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
					<u>Virginia</u>		<u>U. S.</u>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles Bolden</u>				<u>Lou Ingraham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>581.0</u>		<u>40 days</u>
IMMEDIATE CAUSE (A) <u>Uremia</u>		
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>1 year</u>
(B) <u>Chronic's Sore</u>		
DUE TO		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
<u>0</u>	<u>C</u>	

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/1/56, 1956 to 1/14/56, 1956 that I last saw the deceased alive on 1/14/56, 1956 and that death occurred at 11:35 M, from the causes and on the date stated above.

SIGNATURE [Signature] ADDRESS [Address] DATE SIGNED 1/14/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1-17-56</u>	<u>Rock Creek Cemetery</u>	<u>Washington, D.C.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Jan 14 5-6</u>	<u>Bertine B. Lawler</u>	<u>J. Arthur Patterson</u>	<u>254 Carroll St. NW. Wash. D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 19 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

COUNTY **Montgomery** MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) **Bethesda Rural**
 TOWN **Bethesda Rural** LENGTH OF STAY (in this place) **lmo 3 days**

HOSPITAL OR INSTITUTION OR STREET ADDRESS **U. S. Naval Hospital**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **District of Columbia** COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Washington, D.C.**

STREET ADDRESS (If rural give location) **3114 16th Street, N.E.**

3. NAME OF DECEASED:

(First) **Robert**(Middle) **Stewart**(Last) **BONAR**4. DATE (Month) (Day) (Year) OF DEATH: **January 22 19 56**5. SEX: **Male**6. COLOR OR RACE: **White**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **Married**8. DATE OF BIRTH: **3-6-92**9. AGE last birthday **63** yrs.

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Civil Service**10B. KIND OF BUSINESS OR INDUSTRY: **U.S. Government**11. BIRTHPLACE (State or foreign country): **Washington, D.C.**12. CITIZEN OF WHAT COUNTRY? **US**

13. FATHER'S NAME:

Robert BONAR

14. MOTHER'S MAIDEN NAME:

Elizabeth MC KERICHAR15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) **Yes WW I**16. SOCIAL SECURITY NO. **None**17. INFORMANT & ADDRESS: **Son Mr. Robert S. BONAR Jr. Same as above**

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X

IMMEDIATE CAUSE

(A) **Mnesia**

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) **Arteriolar nephrosclerosis**(C) **Hypertensive cardiovascular disease approx 1 yr.**

INTERVAL BETWEEN ONSET AND DEATH

2 months**approx 1 year****approx 1 yr.**

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **19 Dec, 1955**, to **22 Jan, 1956**, that I last saw the deceased alive on **22 Jan, 1956**, and that death occurred at **9:05A.M.**, from the causes and on the date stated above.SIGNATURE **M. D. Willcuts, Jr.**

ADDRESS

DATE SIGNED

M. D. WILLCUTTS JR LTJG, MC USNR U. S. Naval Hospital, NNMC, Bethesda, Maryland

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial**25 Jan 56****Arlington National Cemetery****Arlington, Virginia**

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

22 Jan 1956**Mayb. Parrelly****HINES Funeral Home****2901 14th Street, N.W. Washington, D.C.**

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 27 1956

RECEIVED

754

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 2 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 12301 Atherton Drive			
3. NAME OF DECEASED: (First) (Middle) (Last) Patrick William BOWEN				4. DATE (Month) (Day) (Year) OF DEATH: January 31 19 56			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH: 1-29-56	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None			10B. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (State or foreign country): Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: James W. BOWEN				14. MOTHER'S MAIDEN NAME: Andrea T. WOODIN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) - -				16. SOCIAL SECURITY NO. None		17. INFORMANT'S ADDRESS: Father LCDR James W. BOWEN USN Same as above	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) meningitis							1 day
ANTECEDENT CAUSE (S) DUE TO (B) Rupt meningococci							2 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hydrocephalus - congenital							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County)	(State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 29 Jan., 1956 , to 31 Jan., 1956 , that I last saw the deceased alive on 31 Jan 56 , and that death occurred at 1:00P M, from the causes and on the date stated above.							
SIGNATURE Howard A. Pearson				ADDRESS DATE SIGNED			
Howard A. PEARSON LT, MC, USN U. S. Naval Hospital, NNMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2 Feb 1956		Arlington National Cemetery		Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
1 Feb 1956		Mary E. Parrelly		W. E. Humphrey Funeral Home		Georgia Avenue, Silver Spring, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 6 1956

RECEIVED

755

CERTIFICATE OF DEATH

Reg. Dist. No. 246

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>6 days 10 hours</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rockville</u> 26			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>Normandy Farms</u> 1			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JAMES</u> <u>BROWN</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>1 - 13 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widower</u>	8. DATE OF BIRTH: <u>6-23-75</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>UNK.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mr. A. Basselatt - Normandy Farms Rockville, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardiac failure</u>							<u>15 min</u>
ANTECEDENT CAUSE (B) <u>Acute pancreatitis</u>							<u>1 week</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>undetermined</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>gen. arteriosclerosis</u>							<u>Indef</u>
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/8/1953</u> , to <u>1/13/1956</u> , that I last saw the deceased alive on <u>1/13/1956</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stephen H. Jones</u>		M.D. <u>Rockville, Md.</u>		DATE SIGNED <u>1/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-16-56</u>		<u>Lincoln Park</u>		<u>Rockville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-16-56</u>		<u>Bennie M. Thompson</u>		<u>Robert L. Snowden</u>		<u>Rockville, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 18 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

712

00712

Reg. Dist. No. 223

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write OR and give nearest town) <u>Lake Park</u>		LENGTH OF STAY (in this place) <u>D.D.G.</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Sanatorium Hospital</u>				STREET ADDRESS (If rural, give location) <u>2706 Arcola</u>			
3. NAME OF DECEASED: (First) <u>Donald</u> (Middle) <u>Lee</u> (Last) <u>Browning</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>2-?-36</u>	
9. AGE last birthday: <u>19</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Army</u>		11. BIRTHPLACE (State or foreign country): <u>Charleston W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>?</u>				14. MOTHER'S MAIDEN NAME: <u>Vivian Pennington</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes-Active</u>		16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>Stephan - Mr. Simons - 2706 Arcola S.S. Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Hemorrhage - massive internal</u>						<u>15 min.</u>	
DUE TO							
Antecedent cause(s) (b) <u>Communitated fractures of Pelvis + Rt Femur</u>						<u>15 min.</u>	
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) <u>Auto-accident</u>						<u>15 min.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>825X</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>street</u>		21c. (City or town) (County) (State) <u>Silver Spring Montgomery Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>15</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto Accident</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John S. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12 Jan 1956</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan 4 - 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Nat Cemetery Ft Meyer, Va</u>		LOCATION (City, town, or county) (State) <u>816 Ft. St N.E. Wash, D.C.</u>	
DATE REC'D BY LOCAL REG. <u>Jan 1 - 1956</u>		REGISTRAR'S SIGNATURE <u>J. H. H. Dodel</u>		24. FUNERAL DIRECTOR <u>Prinaldi Funeral Home</u>		ADDRESS <u>816 Ft. St N.E. Wash, D.C.</u>	

RECEIVED

JAN 4 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 218

756

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Montgo.</i>
CITY (If outside corporate limits, write OR and give nearest town) <i>Unity</i>	RURAL LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write OR and give nearest town) <i>Unity</i>	RURAL LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Brookville, P.O. #1</i>		STREET ADDRESS (If rural give location) <i>Brookville - P.O. #1</i>	
3. NAME OF DECEASED: (Type or Print) <i>Virginia Burkley</i>		4. DATE OF DEATH: (Month) (Day) (Year) <i>Jan. 17 1956</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>Caucasian</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>March 15, 1854</i>
9. AGE last birthday: <i>101</i>		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Home</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Richard Higgs</i>		14. MOTHER'S MAIDEN NAME: <i>Fannie - unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY No.: <i>no</i>	
17. INFORMANT & ADDRESS: <i>Laura Howard, Brookville, Md. P.O. #1</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
<p>422.1 Immediate cause (a) <i>Arteriosclerotic cardiovascular disease</i></p> <p>Antecedent causes (s) (b) <i>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.</i></p> <p>(c)</p>		<i>50 years.</i>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Rheumatoid arthritis</i>		<i>15 years.</i>
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>Jan. 15, 1952</i> , to <i>Jan. 17, 1956</i> , that I last saw the deceased alive on <i>Jan. 16, 1956</i> , and that death occurred at <i>from the causes and on the date stated above.</i>		
SIGNATURE <i>James V. Kerr M.D.</i>		DATE SIGNED <i>1/18/56</i>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<i>Burial</i>	<i>1-21-56</i>	<i>Howard Chapel</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<i>Jan. 21-56</i>	<i>Charles L. Cooke</i>	<i>Robert L. Snowden - Rockville, Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 24 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

757 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00714

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Bethesda</u> TOWN <u>Bethesda</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Bethesda</u> TOWN <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8614 Lancaster Drive</u>				STREET ADDRESS (If rural give location) <u>8614 Lancaster Drive</u>			
3. NAME OF DECEASED:		(First) <u>Louise</u> (Middle) <u>E.</u> (Last) <u>BUTLER</u>		4. DATE OF DEATH:		(Month) (Day) (Year) <u>January 10, 1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>January 25,</u>	<u>88</u> yrs.	<u>11</u> Months	<u>15</u> Days	<u></u> Hours <u></u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown Margaret L</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Bragaw Daughter- 8614 Lancaster Dr. Beth Md.</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>June 1, 1955</u> , to <u>June 10, 1956</u> , that I last saw the deceased alive on <u>12/12</u> , 19 <u>55</u> , and that death occurred at <u>9:30 A</u> -M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. Joseph Kinnick</u>				ADDRESS <u>M. D. 6450 Wisconsin Ave. Beth. Md</u>			
DATE SIGNED <u>1/12/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF <u>1-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Prince Georges Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/12/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert C. Humphrey</u>		ADDRESS <u>Bethesda Md</u>	

BUREAU V. S.

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00715

753

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D. C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Kensington</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u> <u>47x-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Carroll Hall Nursing Home</u>				STREET ADDRESS (If rural give location) <u>3411 20th St., N.E.</u>			
3. NAME OF DECEASED: (Type or Print) <u>JESSIE A. CAKE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>JAN. 14</u> <u>1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>July 7, 1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired homemaker - own home</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Fanning Barnard</u>				14. MOTHER'S MAIDEN NAME: <u>Linda Harvey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr. Lawrence Cake, 2500 Wisconsin Ave., N.W. Washington, D. C.</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>170X</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>CARCINOMATOSIS</u>							
DUE TO							
(B) <u>SECONDARY TO MAMMARY CARCINOMA</u>							
DUE TO							
(C) <u>DIABETIS MELLITIS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ARTERIOSCLEROTIC HEART DISEASE</u>							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION: <u>NONE</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-27, 1953</u> , to <u>1-14, 1956</u> , that I last saw the deceased alive on <u>1-14</u> , 1956, and that death occurred at <u>6: A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James P. Linder</u>				DATE SIGNED <u>1-14-56</u>			
ADDRESS <u>5206 N. ...</u>							
M. D. <u>Cham ...</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-16-56</u>		REGISTRAR'S SIGNATURE <u>James P. Linder</u>		24. FUNERAL DIRECTOR <u>Warner & Pumphrey</u> ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>			

BUREAU V. S.

JAN 18 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

753

CERTIFICATE OF DEATH

00716

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>1 1/2</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>		<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>2604 Avena Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CLARA</u> (Middle) <u>MARTIN</u> (Last) <u>CALL</u>				(Month) <u>JAN.</u> (Day) <u>17</u> (Year) <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 29, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Greensboro, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George F. Martin</u>				14. MOTHER'S MAIDEN NAME <u>Ann Blosser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Martha Labin, 2604 Avena St. Silver Spring, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion with</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Infarction</u>				<u>1 week</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized Arteriosclerosis</u>				<u>10 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/10/55</u> , to <u>1/17/56</u> , that I last saw the deceased alive on <u>1/17/56</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>John J. Curry</u> M.D. <u>11301 Georgia Ave</u> DATE SIGNED <u>1/17/56</u> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Trans. & Burial</u>		DATE THEREOF <u>1/19/56</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		LOCATION (City, town, or county) (State) <u>Waynesburg, Greene Co., Pa.</u>	
24. REC'D BY REGISTRAR DATE <u>1-19-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

760

00717

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Bethesda Rural</u>		LENGTH OF STAY (in this place) <u>5 minutes</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Rockville</u>		<u>26</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural, give location) <u>15 Paca Place</u>			
3. NAME OF DECEASED: (First) <u>Mary</u>		(Middle) <u>Lee</u>		(Last) <u>CARLIN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 17 19 56</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>12-8-54</u>	9. AGE last birthday: <u>1</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Michael J. CARLIN</u>				14. MOTHER'S MAIDEN NAME: <u>Leah SHINKLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>- -</u>		17. INFORMANT & ADDRESS: <u>Father Capt Michael J. CARLIN USAF</u> <u>Same as above</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>492 X</u> Immediate cause (a) <u>Pneumonia, interstitial</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				<u>detected</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Frank J. Brochart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u>1-18-56</u> M. D.			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>20 Jan 56</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REG. <u>18 Jan 1956</u>		REGISTRAR'S SIGNATURE <u>Mary G. Carrelly</u>		24. FUNERAL DIRECTOR <u>R. A. Humphrey Funeral Home</u> ADDRESS <u>7557 Wisconsin Ave., Bethesda, Md.</u>	

BUREAU V. S.

JAN 24 1935

RECEIVED

Handwritten signature or stamp, possibly "Handwritten" or "Handwritten" in a stylized script.

10 Jan 1935

20 Jan 35

20 Jan 35

10 Jan 35

738

CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write and give nearest town) <u>Rockville</u>	RURAL <u>Life</u>	CITY (If outside corporate limits, write and give nearest town) <u>Rockville</u>	RURAL <u>Life</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>240 N. Washington St.</u>		STREET ADDRESS (If rural give location) <u>240 N. Washington St.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Lucy</u> (First) <u>Carroll</u> (Middle) <u>Carroll</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>January 23 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE <u>MARRIED</u> WIDOWED <u>DIVORCED</u> (Specify):	8. DATE OF BIRTH: <u>April 25 1874</u>
9. AGE last birthday: <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____	11. IF UNDER 24 HRS: Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James W. Carroll</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret E. Norris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Margaret Browne - Rockville, md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE <u>446X</u>		
(A) <u>Anuria, Anoxia, Dehydration</u>		<u>2 weeks</u>
DUE TO		
ANTECEDENT CAUSE (S)		
(B) <u>Hypertension Arteriosclerosis</u>		<u>1948</u>
DUE TO		
(C) <u>Chronic Nephritis without edema</u>		<u>1948</u>
DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Gall bladder or Hepatitis</u>		
19A. DATE OF OPERATION: <u>None</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u>	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>May 4, 1948</u> , to <u>Jan 23, 1956</u> , that I last saw the deceased alive on <u>Jan. 23 1956</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.		
SIGNATURE <u>Webster Sewell</u>	ADDRESS <u>Rockville, Md.</u>	DATE SIGNED <u>1-25-56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1-25-56</u>	NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>
LOCATION (City, town, or county) (State) <u>Rockville, md</u>	24. FUNERAL DIRECTOR <u>Robert L. Sworden</u>	ADDRESS <u>Rockville, md</u>
DATE REC'D BY LOCAL REGISTRAR <u>1/25/56</u>	REGISTRAR'S SIGNATURE <u>Laurel H. Singler</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 26 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00719

761

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Virginia</i>		COUNTY	
CITY (If outside corporate limits, write OR and give nearest town) <i>X</i>		RURAL LENGTH OF STAY (in this place) <i>80 da</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Roanoke</i>		<i>83x-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>50 Nat'l Inst. Health</i>				STREET ADDRESS (If rural give location) <i>Darlington Rd.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Charles Daniel Clark</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>Jan 2 1956</i>			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH: <i>9-21-37</i>	9. AGE last birthday: <i>18</i>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Student</i>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME: <i>Charles F. Clark</i>				14. MOTHER'S MAIDEN NAME: <i>Louise Kessler</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT & ADDRESS: <i>Mother -</i>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>353.3</i>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <i>Asphyxia</i>							
DUE TO							
(B) <i>Epilepsy</i>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>10/24/55</i> , to <i>1/2</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>1/2</i> , 19 <i>56</i> , and that death occurred at <i>2: A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Henry N. Wagner, Jr.</i>		M. D. <i>N.I.H.</i>		ADDRESS		DATE SIGNED <i>Jan 2, 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial - Transit</i>		<i>1/2/56</i>		<i>Fairview Cem.</i>		<i>Roanoke, Va.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>1/3/56</i>		REGISTRAR'S SIGNATURE <i>Leslie M. Thompson</i>		24. FUNERAL DIRECTOR		ADDRESS	
				<i>W.W. Chamber Co. 1400 Chapin St Wash</i>		<i>D.C.</i>	

BUREAU V. S.

JAN 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

762

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Virginia		COUNTY Alexandria	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda		LENGTH OF STAY (in this place) 11 days		CITY (If outside corporate limits, write RURAL and give nearest town) Alexandria		83x-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center Bethesda 14, Maryland				STREET ADDRESS (If rural give location) 301 East Glebe Road			
3. NAME OF DECEASED: (First) (Middle) (Last) Aurelia May Clarke				4. DATE (Month) (Day) (Year) OF DEATH: January 25, 19 56			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: August 4, 1898	9. AGE last birthday 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk		10B. KIND OF BUSINESS OR INDUSTRY: --		11. BIRTHPLACE (State or foreign country): District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Calvin Kennedy				14. MOTHER'S MAIDEN NAME: Mary Burgess			
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) Not available		17. INFORMANT & ADDRESS: The Medical Record, The Clinical Center			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) acute myelocytic leukemia							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 14, 1956, to Jan. 25, 1956 that I last saw the deceased alive on Jan. 25, 1956, and that death occurred at 1:12 AM, from the causes and on the date stated above SIGNATURE Robert J. Levine ADDRESS M. D. The Clinical Center, NIH, Bethesda, Md. DATE SIGNED 1/25/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 1-25-56		NAME OF CEMETERY OR CREMATORY Arlington Va		LOCATION (City, town, or county) (State) Arlington County Va	
DATE REC'D BY LOCAL REGISTRAR 1-25-56		REGISTRAR'S SIGNATURE Bessie M. Thompson		24. FUNERAL DIRECTOR Cunningham F. Rome		ADDRESS Alexandria	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 30 1958

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

763 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00721

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>12 day</u>		CITY (If outside corporate limits, write and give nearest town) <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS (If rural give location) <u>Ht. #3</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>William Henry Capeland</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1-3-1956</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>of</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>2-10-84</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Cash</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>retired</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Gratton Capeland</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Lucille Capeland - daughter</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>						<u>4 day</u>	
ANTECEDENT CAUSE (B) <u>Arterio-sclerosis</u>						<u>years -</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATE UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/1</u> , 19 <u>56</u> , to <u>1/3</u> , 19 <u>56</u> that I last saw the deceased alive on <u>1/3</u> , 19 <u>56</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Richard S. Norton</u>		ADDRESS <u>Bethesda Md</u>		DATE SIGNED <u>1/3/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>Brooke Grove</u>		LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/9/56</u>		REGISTRAR'S SIGNATURE <u>Anna M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville Md</u>	

RECEIVED

JAN 11 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE District of Columbia	COUNTRY
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural	LENGTH OF STAY (in this place) 25 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C.	47X-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural give location) 1400 Fairmont Street, N.W.	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) William	(Middle) Eugene	(Last) CORDELL	OF DEATH: January 3 1956
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 7-15-94
9. AGE last birthday 61 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Floor Refinisher	10B. KIND OF BUSINESS OR INDUSTRY: Maintenance	11. BIRTHPLACE (State or foreign country): Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? US
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13. FATHER'S NAME: William CORDELL		14. MOTHER'S MAIDEN NAME: Lucy RYAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT & ADDRESS: Wife Mrs. Grace P. CORDELL		Same as above	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) BRONCHOPNEUMONIA		1 week
ANTECEDENT CAUSE (S) DUE TO (B) BRONCHOSTENOSIS, left main stem		8 mos. +
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) BRONCHOGENIC CARCINOMA METASTASES WITH		8 mos. +
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. ATHEROSCLEROSIS, WIDESPREAD		20+ yrs.

19A. DATE OF OPERATION: 2	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **8 Dec**..., 19**55** to **3 Jan**..., 19**56** that I last saw the deceased alive on **3 Jan**..., 19**56**, and that death occurred at _____ M, from the causes and on the date stated above.

SIGNATURE **W. B. INGRAM CDR, MC, USN U. S. Naval Hospital, NNMC, Bethesda, Maryland** ADDRESS _____ DATE SIGNED _____

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 6 Jan 1956	NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	LOCATION (City, town, or county) (State) Arlington, Virginia
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DATE REC'D BY LOCAL REGISTRAR 3 Jan 1955	REGISTRAR'S SIGNATURE Mary E. Crandall	24. FUNERAL DIRECTOR S. H. HINES Funeral Home	ADDRESS 2901 14th Street, N.W. Washington, D.C.
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 9 1956

RECEIVED

765

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00723

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Kentucky	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural	LENGTH OF STAY (in this place) 31 days	CITY (If outside corporate limits, write RURAL and give nearest town) Garrison	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital	STREET ADDRESS (If rural give location) 55X-3		
3. NAME OF DECEASED: (First) (Middle) (Last) Christinia Agnes COTTON		4. DATE (Month) (Day) (Year) OF DEATH: January 29 1956	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 4-12-16
9. AGE last birthday 39 yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Housewife	
11. BIRTHPLACE (State or foreign country): New Hampshire		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Harold CLOUGH		14. MOTHER'S MAIDEN NAME: Harriett BILBRUCK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT & ADDRESS: Husband Carl W. COTTON Same as above			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 199.8		approx.	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		20 days.	
(A) Pulmonary Edema & Cardiac failure			
(B) metastatic carcinoma of pleura			
(C) mediastinum & diaphragm			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Intestinal obstruction, recurrent			
19A. DATE OF OPERATION: 35 January 1956		19B. MAJOR FINDINGS OF OPERATION: Carcinomatous Mesenteric Mass & Intest. Obstruction	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 29 Dec., 1955 , to 29 Jan., 1956 , that I last saw the deceased alive on 29 Jan., 1956 , and that death occurred at 10:50 A.M. , from the causes and on the date stated above.			
SIGNATURE B. C. JOHNSON LT, MC, USN U. S. Naval Hospital, NNMC, Bethesda, Maryland		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2 Feb 1956	
NAME OF CEMETERY OR CREMATORY Warren Cemetery		LOCATION (City, town, or county) (State) Garrison, Kentucky	
DATE REC'D BY LOCAL REGISTRAR 30 Jan 1956		REGISTRAR'S SIGNATURE Mary E. Gassell	
24. FUNERAL DIRECTOR R. A. Humphrey Funeral Home		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 6 1956

RECEIVED

766

CERTIFICATE OF DEATH

Reg. Dist. No. 217.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Carroll</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Dinny</u>	LENGTH OF STAY (in this place) <u>1 yr. 7 mo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Airy - 06X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sharon Chronic Hosp.</u>	STREET ADDRESS (If rural give location) <u>✓</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Leannah B. Crockett</u>		OF DEATH: <u>Jan-4 1956</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W-</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>July 9, 1863</u>
9. AGE last birthday <u>92</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Kemptown Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Greenberry Baker</u>		14. MOTHER'S MAIDEN NAME: <u>Hepzibah Brandenburg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Sharon Chronic Hosp. records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>450.0</u>		<u>2 yrs.</u>	
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(A) <u>Cardiac Exhaustion</u>	
		DUE TO	
		(B) <u>Debility, Senility + gen.</u>	
		DUE TO	
		(C) <u>For advanced Art. Sclerosis</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5-31-1954</u> to <u>1-4-1956</u> , that I last saw the deceased alive on <u>1-4-</u> , 1956, and that death occurred at <u>2:30 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>John B. Ziegler</u>		ADDRESS <u>M. D. Alney, Md</u>	
DATE SIGNED <u>1-4-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 7, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Providence</u>		LOCATION (City, town, or county) (State) <u>Kemptown, Fred. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-6-56</u>		REGISTRAR'S SIGNATURE <u>Bertinda B. Lawler</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Olin L. Molesworth, Damascus, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATEMENT OF DEATH

1. Name of deceased: _____

2. Date of death: _____

3. Place of death: _____

4. Cause of death: _____

5. Name of physician: _____

6. Name of funeral home: _____

7. Name of next of kin: _____

8. Name of informant: _____

9. Name of registrar: _____

10. Name of registrar: _____

11. Name of registrar: _____

12. Name of registrar: _____

13. Name of registrar: _____

14. Name of registrar: _____

15. Name of registrar: _____

16. Name of registrar: _____

17. Name of registrar: _____

18. Name of registrar: _____

19. Name of registrar: _____

20. Name of registrar: _____

21. Name of registrar: _____

22. Name of registrar: _____

23. Name of registrar: _____

24. Name of registrar: _____

25. Name of registrar: _____

26. Name of registrar: _____

27. Name of registrar: _____

28. Name of registrar: _____

29. Name of registrar: _____

30. Name of registrar: _____

BUREAU V. S.

JAN 9 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Ohio	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural	LENGTH OF STAY (in this place) 4mo 2 days	CITY (If outside corporate limits, write RURAL and give nearest town) Columbiana	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural give location) Elkton Road	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) Jervace	(Middle) Letha	(Last) CROUSE	(Month) January (Day) 17 (Year) 1956
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 2-12-05
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy Nurse		10B. KIND OF BUSINESS OR INDUSTRY: Navy	9. AGE last birthday 50 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
11A. FATHER'S NAME: Elmer H. CROUSE		11B. BIRTHPLACE (State or foreign country): Ohio	
12A. MOTHER'S NAME: Nettie REESH		12B. CITIZEN OF WHAT COUNTRY? US	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW II & Korea		14. SOCIAL SECURITY NO. Unknown	
15. INFORMANT'S NAME: Brother Mr. Andrew CROUSE		16. ADDRESS: Same as above	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) Pulmonary edema	DUE TO	? 2 days
ANTECEDENT CAUSE (S) (B) Metastatic melanoma	DUE TO	1 year
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Melanoma, left eye	DUE TO	2 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 15 Sept, 1955 , to 17 Jan, 1956 , that I last saw the deceased alive on 17 Jan, 1956 , and that death occurred at 7:50 PM , from the causes and on the date stated above.				
SIGNATURE F. W. MYER CDR, MC, USN U. S. Naval Hospital, NMMC, Bethesda, Maryland		ADDRESS		DATE SIGNED
23. BURIAL, CREMATION, REINTERMENT (SPECIFY) Burial		DATE THEREOF 21 Jan 1956		NAME OF CEMETERY OR CREMATORY Columbiana Cemetery
LOCATION (City, town, or county) (State) Columbiana, Ohio				
DATE REC'D BY LOCAL HEALTH DEPT. 18 Jan 1956		REGISTRAR'S SIGNATURE Mary E. Casella		FUNERAL DIRECTOR'S ADDRESS R. A. Humphrey Funeral Home 7557 Wisconsin Avem, Bethesda, Md.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 24 1956

RECEIVED

Items 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100
768
film G199 7-10-56
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: <u>Kenwood</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write TOWN and give nearest town) <u>Kenwood</u>	LENGTH OF STAY (in this place) <u>25 yrs</u>	CITY (If outside corporate limits, write TOWN and give nearest town) <u>Kenwood</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5331 Chamberlin Ave Kenwood, Md</u>		STREET ADDRESS (If rural give location) <u>5331 Chamberlin Ave</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Judson Thomas Cull Jr.</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>1 - 29 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>1882 10 - 16 - 1883</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Lawyer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Law</u>	9. AGE last birthday <u>73</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <u>Washington, DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Judson Thomas Cull</u>		14. MOTHER'S MAIDEN NAME: <u>Mary M Lanahana</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service) <u>None</u>		15. SOCIAL SECURITY No. <u>None</u>	
16. INFORMANT & ADDRESS: <u>Florence Cull</u>		17. INFORMANT & ADDRESS: <u>5331 Chamberlin Ave Kenwood, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Uremic Coma</u>		<u>8 hour</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Atherosclerotic Kidneys</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Atherosclerosis</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Mitral Stenosis Aortic Regurgitation</u>		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>Nov 12, 1955</u> , to <u>Jan 24, 1956</u> that I last saw the deceased alive on <u>Jan 28, 1955</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.		
SIGNATURE <u>Hance H. Sharpe</u>	ADDRESS <u>M. D. 3328 O-St. N.W. Wash. Dc.</u>	DATE SIGNED <u>1-29-56</u>

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>	DATE THEREOF <u>1-30-56</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
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DATE REC'D BY LOCAL REGISTRAR <u>1-31-56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR'S ADDRESS <u>Bethesda, Md.</u>
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MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 3 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

769

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00727

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u> LENGTH OF STAY (in this place) <u>3 days</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington, D.C.</u> 476-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural, give location) <u>3120 Silver Mt. N.W.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>William Clancy Cunningham</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1 - 15 - 1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>9-16-88</u>	
9. AGE last birthday <u>67</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>James C. Cunningham</u>			
14. MOTHER'S MAIDEN NAME <u>Henrietta Manlove</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, of date of service) <u>yes W.W.I.</u>			
16. SOCIAL SECURITY No. _____				17. INFORMANT AND ADDRESS <u>Ellis Cunningham (wife)</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>416X Congestive Heart Failure</u>						<u>15 mos.</u>	
Antecedent cause(s) <u>Healed Bacterial Endocarditis</u>						<u>17 mos.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Rheumatic Heart Disease</u>						<u>years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION _____			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify) _____		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY _____		(CITY OR TOWN) _____		(COUNTY) _____ (STATE) _____	
TIME (Month) (Day) (Year) (Hour) OF INJURY _____		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Aug.</u> , 19 <u>54</u> , to <u>Jan. 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 15</u> , 19 <u>56</u> , and that death occurred at <u>5:10 p.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert D. Howell M.D.</u> (Degree or title)				ADDRESS <u>5516 Nebraska Ave D.C.</u>		DATE SIGNED <u>1-15-56</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-18-56</u>		NAME OF CEMETERY OR CREMATORY <u>Washington, D.C.</u>		LOCATION (City, town, or county) (State) _____	
DATE REC'D BY LOCAL REG. <u>1-16-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>4812 24th St. N.W.</u> ADDRESS <u>Washington, D.C.</u>			

RECEIVED

JAN 19 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE West Virginia	COUNTY --
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda	LENGTH OF STAY (in this place) 99 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dothan, West Virginia 85x-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center Bethesda, Maryland	STREET ADDRESS (If rural give location) Box 150		

3. NAME OF DECEASED: (First) (Middle) (Last) Theodore Roosevelt Daniels		4. DATE (Month) (Day) (Year) OF DEATH: Jan. 18, 19 56	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 17 July 1900
9. AGE last birthday 55 yrs.		10. BIRTHPLACE (State or foreign country): West Virginia	11. CITIZEN OF WHAT COUNTRY? U. S. A.
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Timberman		13. KIND OF BUSINESS OR INDUSTRY: Lumber	
14. FATHER'S NAME: William H. Daniels		15. MOTHER'S MAIDEN NAME: Rebecca Daniels	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 232-28-3094	
18. INFORMANT & ADDRESS: The Medical Record, The Clinical Center			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 199.1 IMMEDIATE CAUSE (A) Squamous cell Carcinoma Left Chest Wall + Apella ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Esophageal Ulcerations	
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19A. DATE OF OPERATION: 3 1-13-56	19B. MAJOR FINDINGS OF OPERATION: Squamous cell Carcinoma Left Chest Wall + Apella	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 11 1955 , to Jan. 18, 1956 , that I last saw the deceased alive on Jan. 18 , 1956, and that death occurred at 7:10AM , from the causes and on the date stated above.	
SIGNATURE Ross M. Miller, Jr.	DATE SIGNED 1-18-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-transit	DATE THEREOF 1/20/56	NAME OF CEMETERY OR CREMATORY Peters Cemetery	LOCATION (City, town, or county) (State) Fayette Co. W. Virginia
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DATE REC'D BY LOCAL REGISTRAR 1-31-56	REGISTRAR'S SIGNATURE Beau M. Thompson	24. FUNERAL DIRECTOR Robert A. Humphrey	ADDRESS Bethesda, Md.
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MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 3 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	District of Columbia	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda	LENGTH OF STAY (in this place) 14 days	CITY (If outside corporate limits, write RURAL and give nearest town) Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center National Inst. of Health	STREET ADDRESS (If rural give location) 1845 M. Street N. E. Apt 2		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) Dianna	(Middle) Telcia	(Last) Dean	
5. SEX: Female		6. COLOR OR RACE: Negro	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: April 10, 1955	
9. AGE last birthday: 9 yrs. 9 Months 14 Days 14 Hours 14 Min.		10. BIRTHPLACE (State or foreign country): New Jersey	
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Berlin Dean		14. MOTHER'S MAIDEN NAME: Delores Carter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: The Medical Record, The Clinical Center			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) VENTRICULAR FIBRILLATION			
ANTECEDENT CAUSE (S) CARDIAC SURGERY			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. ANOMALOUS LEFT CORONARY ARTERY			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 1/24/56		19B. MAJOR FINDINGS OF OPERATION: LEFT VENTRICULAR INFARCTION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 10, 1956 , to Jan 24, 1956 , that I last saw the deceased alive on Jan 24, 1956 , and that death occurred at 6:00 P.M. , from the causes and on the date stated above.			
SIGNATURE Robert A. Salerno		DATE SIGNED 1/25/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/27/56	
NAME OF CEMETERY OR CREMATORY Burlington Natl. Cemetery		LOCATION (City, town, or county) (State) Washington, D.C.	
DATE REC'D BY LOCAL REGISTRAR 1-26-56		24. FUNERAL DIRECTOR Robert G. McQuire	
REGISTRAR'S SIGNATURE Bennie M. Thompson		ADDRESS 1820-4 48th St. N.W.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 30 1956

RECEIVED

772

CERTIFICATE OF DEATH

Reg. Dist. No. 216....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <i>Bethesda</i>		4 days		TOWN <i>Rockville</i>		26	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburban Hospital</i>				STREET ADDRESS (If rural give location) <i>1625 Lewis Avenue</i>			
3. NAME OF DECEASED: (First) <i>John</i> (Middle) <i>Joseph</i> (Last) <i>DeLarco</i>				4. DATE (Month) (Day) (Year) OF DEATH <i>Jan. 31 1956</i>			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE OR MARRIED, WIDOWED, DIVORCED, (Specify): <i>W</i>	8. DATE OF BIRTH: <i>March 21-1892</i>	9. AGE last birthday: <i>63</i> yrs.	IF UNDER 1 YEAR: Months <i>10</i> Days <i>10</i>	IF UNDER 24 HRS. Hours <i>10</i> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Barber</i>			10B. KIND OF BUSINESS OR INDUSTRY: <i>Self-Employed</i>		11. BIRTHPLACE (State or foreign country): <i>Philadelphia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME: <i>John Lewis DeLarco</i>				14. MOTHER'S MAIDEN NAME: <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <i>1625 Lewis Ave Jacqueline Jabler daughter</i>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.1 IMMEDIATE CAUSE				<i>5 days</i>			
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(A) <i>confluent bronchopneumonia</i>			
				DUE TO			
				(B) <i>massive myocardial infarct, old & recent</i>			
				DUE TO			
				(C) <i>coronary artery disease</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<i>2 years</i>			
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>1/27</i> , 1956 to <i>1/31</i> , 1956 that I last saw the deceased alive on <i>1/31</i> , 1956, and that death occurred at <i>8:00</i> P.M., from the causes and on the date stated above.							
SIGNATURE <i>Charles J. Savarese</i>				ADDRESS <i>4868 Patton Rd. Bethesda</i>		DATE SIGNED <i>2/4/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>2-3-56</i>		<i>Rockville Union</i>		<i>Rockville Montg. Co. Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2/4/56</i>		REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>		24. FUNERAL DIRECTOR <i>Robert A. Humphrey</i>		ADDRESS <i>Bethesda, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

02-2200

BUREAU V. S.

FEB 6 1956

RECEIVED

773

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Dist of Col.</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>22 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>		<u>47x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Resmor Sanitarium 5721 Grosvenor Lane</u>				STREET ADDRESS (If rural give location) <u>3620-16th St. NW.</u>			
3. NAME OF DECEASED: (First) <u>Edna</u> (Middle) <u>Holland</u> (Last) <u>Donnelly</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>8</u> <u>1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>9 May 1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Richard Bowie Holland</u>				14. MOTHER'S MAIDEN NAME: <u>Ada Drummond</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-16-6806</u>		17. INFORMANT & ADDRESS: <u>Willis Holland Brown, 4302 Everett St Kensington, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinomatosis, generalized</u>						<u>4+ mos.</u>	
ANTECEDENT CAUSE (S) (B) <u>Carcinoma of colon</u>						<u>6+ mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY <u>street, office bldg., etc.</u>		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 7, 1956</u> to <u>Jan 8, 1956</u> , that I last saw the deceased alive on <u>Jan 7, 1956</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Henry D. Ecker</u>		M. D. <u>917-20th St. N.W.</u>		DATE SIGNED <u>1/8/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/12/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 16 1956

RECEIVED

774
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D. C.</u>		COUNTY <u>--</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
<u>Bethesda</u>		<u>13 days</u>		<u>Washington, D. C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>The Clinical Center Bethesda, Maryland</u>				<u>910 G Street, S. W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Sylvia Louise Driver</u>				<u>Jan. 9, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Negro</u>	<u>Single</u>	<u>30 Oct. 1924</u>	<u>31</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>		<u>Domestic</u>		<u>District of Columbia</u>		<u>U. S. A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Walter Kelly</u>				<u>Blanche (unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No.</u> (If Yes, give war or dates of service) <u>--</u>		<u>Not available</u>		<u>The Medical Record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
204.0 IMMEDIATE CAUSE (A) <u>Gastrointestinal + Pulmonary Hemorrhage</u>							<u>1 wk.</u>
ANTECEDENT CAUSE (S) (B) <u>Thrombocytopenia</u>							<u>2 wks.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Acute Lymphocytic Leukemia</u>							<u>7 mos.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>Dec. 27, 1955</u> , to <u>Jan. 9, 1956</u> that I last saw the deceased alive on <u>Jan. 9, 1956</u> , and that death occurred at <u>6:24 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas L. Gorsuch, M.D.</u>				ADDRESS <u>The Clinical Center, NIH, Bethesda, Md.</u> DATE SIGNED <u>1/9/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-14-56</u>		<u>Lincoln Mem. Cem.</u>		<u>Suitland, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1/10/56</u>		<u>Bessie M. Thompson</u>		<u>Griffin Funeral Home</u>		<u>359 E. L. Ave. N.W. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 12 1956

BUREAU V. S.

500

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00733

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10151 Sutherland Road</u>		STREET ADDRESS (If rural give location) <u>10151 Sutherland Road</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>SUSIE WINIFRED ECKLOFF</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 18 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 20 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE last birthday <u>72</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES A. CAHO</u>		14. MOTHER'S MAIDEN NAME <u>LOTTIE HEISIE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT <u>Granddaughter Mary E. Munster</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute left ventricular failure

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Heart Diseaseseveral yrs.(c) Cerebral hemorrhage (1949) + right hemiplegia6 1/2 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Colostomy (1949)

19a. DATE OF OPERATION

none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

no

PLACE (Home, farm, factory, street, OF office hldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY noneINJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1954, to January, 1956, that I last saw the deceasedalive on January 17, 1956, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

Burial

DATE THEREOF

1-21-56

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

1-20-56

REGISTRAR'S SIGNATURE

Frances Potter

24. FUNERAL DIRECTOR

Martin W. Hyman & Co

ADDRESS

RECEIVED

JAN 23 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

776

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00734

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>15th St</u>		LENGTH OF STAY (in this place) <u>30 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>		56	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hoag</u>				STREET ADDRESS (If rural, give location) <u>1806 Sherwood Rd</u>		1	
3. NAME OF DECEASED: (First) <u>Marion</u> (Middle) <u>Eleanor</u> (Last) <u>Emerick</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>19</u> (Year) <u>56</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>12/31/66</u>	
				9. AGE last birthday: <u>89</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Lewistown, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Emerick</u>				14. MOTHER'S MAIDEN NAME: <u>Rosanna Eleanor Rider</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Ruth E. Reppert, 1806 Sherwood Rd. Silver Spring, Maryland</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebral hemorrhage</u> Antecedent cause(s) (b) <u>Compressed fracture of skull (at occipital)</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)						<u>33 day</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Fracture Rt. hip</u>							
19a. DATE OF OPERATION: <u>1-19-56</u>		19b. MAJOR FINDING OF OPERATION: <u>Fracture Rt. hip</u>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc., INJURY) <u>home</u>		21c. (City or town) (County) (State) <u>Silver Spring Montg md</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>15 12-16-55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell down basement steps</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschant</u>		M. D. <u>Bessie M. Thompson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>1-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Trans. & Burial</u>		DATE THEREOF <u>1/23/56</u>		NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Briella, New Jersey</u>	
DATE REC'D BY LOCAL REG. <u>1-20-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Warren E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

BUREAU V. 1

JAN 23 1956

RECEIVED

00735

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

777

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>D. C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR TOWN
X TOWN <u>Bethesda</u>		TOWN <u>Washington</u>	<u>47x-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>431 Kennedy N.W.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>Baby Bay Evans</u>		OF DEATH: <u>1</u> <u>16</u> <u>1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>--</u>	<u>1-16-56</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<u>Infant</u>		<u>none</u>	<u>Maryland-Bethesda</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>James W. Evans</u>		<u>Doris L. Evans</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>none</u>	
17. INFORMANT & ADDRESS:		Father-James W. Evans <u>431 Kennedy N.W. Wash DC</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) DUE TO	<u>1 day</u>
<u>763.0</u>	<u>Bronchopneumonia</u>	
ANTECEDENT CAUSE (S)	(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
<u>Hypoxia-prolapsed cord</u>		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<u>2</u>		

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 16 JAN, 1956 to 16 JAN, 1956 that I last saw the deceased alive on 16 JAN, 1956 and that death occurred at 5:45 PM, from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
<u>Irwin Pearlman</u>	<u>429 BRADLEY AVE</u>	<u>16 JAN 1956</u>
	M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>1-19-56</u>	<u>Arlington Nat. Cem</u>
		LOCATION (City, town, or county) (State)
		<u>Arlington</u> <u>Virginia</u>

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1/20/56</u>	<u>Bessie M. Thompson</u>	<u>Robert A. Rumphey</u>	<u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 24 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

778

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00736

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>Seneca</u>		<u>3 yrs</u>		<u>James Brookville Md</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural Brookville Md</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(Type or Print)		(First) (Middle) (Last)		OF DEATH:			
<u>Clara</u>		<u>Jane</u>		<u>Everhart</u>		<u>1</u> <u>2</u> <u>1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W.</u>	<u>Married</u>	<u>Oct 18 - 1875</u>	<u>80</u> yrs.	<u>2</u> Months	<u>14</u> Days	<u></u> Hours <u></u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<u>None</u>		<u></u>		<u>Maryland</u>		<u>US</u>	
13. FATHER'S NAME: <u>Jos. McCrossin</u>				14. MOTHER'S MAIDEN NAME: <u>Louisa Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>none</u>		<u>A. S. Everhart, 23 Has the suffix</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE							
(A) <u>Atherosclerosis</u>							<u>years</u>
ANTECEDENT CAUSE (S)							
(B) <u>Cerebral Hemorrhage</u>							<u>34 hrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
260X (C) <u>Diabetes</u>							<u>hrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>0</u> <u>nm</u>		<u></u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/21, 1955</u> , to <u>1/11, 1956</u> , that I last saw the deceased alive on <u>1/11, 1956</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>		DATE SIGNED <u>1/2/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-5-56</u>		<u>Darnestown PresbyCh.Cem</u>		<u>Darnestown Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-6-56</u>		<u>[Signature]</u>		<u>Robert A. Humphrey</u>		<u>Bethesda, Md.</u>	

BUREAU V. S.

JAN 9 1956

RECEIVED

713

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>—</u>		COUNTY <u>— 47X-3</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>		LENGTH OF STAY (in this place) <u>22 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>17 District of Columbia</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75 Wash Sanitarium & Hospital</u>				STREET ADDRESS (If rural give location) <u>215 Cedar Street N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Elvira Mildred Farrell</u>				<u>1 - 2 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Widow</u>		8. DATE OF BIRTH: <u>10-18-85</u>	
9. AGE last birthday: <u>70</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		10. BIRTHPLACE (State or foreign country): <u>Iowa</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>—</u>				13. KIND OF BUSINESS OR INDUSTRY: <u>—</u>			
14. FATHER'S NAME: <u>Charles Curtiss</u>				15. MOTHER'S MAIDEN NAME: <u>Rebecca Maddox</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service): <u>—</u>				17. SOCIAL SECURITY NO.: <u>—</u>			
18. MEDICAL CERTIFICATION				19. INFORMATION & ADDRESS: <u>Hospital Records.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>332X Encephalomalacia</u>				<u>10 days</u>			
ANTECEDENT CAUSE (S) (B) <u>Thrombosis Left Cerebral Artery</u>				<u>10 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>260X Cerebral Arteriosclerosis</u>				<u>? years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>				<u>10 1/2 years</u>			
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) M.		21F. PLACE OF INJURY		21G. WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21H. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 1955</u> , to <u>Jan 2, 1956</u> , that I last saw the deceased alive on <u>Jan 2, 1956</u> , and that death occurred at <u>11:15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Robert A. Hare</u>				ADDRESS <u>Takoma Park Md</u> DATE SIGNED <u>1/3/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 5, 1956</u>		<u>National Memorial Park</u>		<u>Falls Church, Va</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 4 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>254 Carroll St. N.W. Takoma Park, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 6 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		STATE <u>MD.</u> COUNTY <u>Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>8510 Garfield St.</u>					
3. NAME OF DECEASED: (Type or Print) <u>Prince George Finlayson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>JAN. 9 1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>April 8 1904</u>	9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Administrative Maritime Service</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Boston, Mass.</u>		11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Smith Finlayson</u>				14. MOTHER'S MAIDEN NAME: <u>Isabel Faulkner Berry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>8510 Garfield St. Sarah Park Finlayson-Bethesda, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Confluent Bronchopneumonia</u>		<u>? days</u>	
ANTECEDENT CAUSE (B) <u>Massive Myocardial Infarct, old</u>		<u>8 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Coronary Arteriosclerosis Advanced</u>		<u>? years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Parkinsonism</u>		<u>? years</u>	

19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
----------------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 Jan., 1956, to 9 Jan., 1956, that I last saw the deceased alive on 8 Jan., 1956, and that death occurred at 7:25 AM, from the causes and on the date stated above.

SIGNATURE <u>[Signature]</u>		ADDRESS <u>M. D. Suburban Hosp. Bethesda, Md.</u>		DATE SIGNED <u>9 Jan 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/12/56</u>	NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>	LOCATION (City, town, or county) <u>Prince George's Co., Md.</u>	(State)	
DATE REC'D BY LOCAL REGISTRAR <u>1/10/56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Wm. J. Hines Co.</u>		ADDRESS <u>Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 12 1933

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

780

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write and give nearest town) <u>Bethesda</u>	RURAL LENGTH OF STAY (in this place) <u>8 days</u>	CITY (If outside corporate limits, write and give nearest town) <u>Silver Spring</u>	<u>56</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural give location) <u>12029 Dalewood Drive</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Raymond</u>	(Middle) <u>Fishburne</u>	(Last) <u>Fleming</u>	OF DEATH: <u>Jan. 28, 1956</u>
5. SEX: <u>Male</u>		6. COLOR (OR RACE): <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>April 3, 1899</u>	
9. AGE last birthday <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Frank J. Fleming</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Elizabeth Ball</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Wife - Hazel Fleming above</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Lacto-intestinal hemorrhage</u>		<u>2 days</u>
ANTECEDENT CAUSE (B) <u>Exsperating peptic ulcer, stomach, for pyloric</u>		<u>2 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Angine, Rt. extremity, thrombosed Rt. iliac artery</u>		<u>4-5 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at 9:45 AM, from the causes and on the date stated above.

SIGNATURE <u>Charles J. Sawarsse</u>	ADDRESS <u>4860 Battery Rd</u>	DATE SIGNED <u>1/28/56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>2/1/56</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington</u>
DATE REC'D BY LOCAL REGISTRAR <u>1-30-56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>The S. H. Jones Co.</u>
		ADDRESS <u>2901-14th St NW</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Rockville</u>				TOWN <u>Rockville</u>		<u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>530 W. Montg. Ave.</u>				STREET ADDRESS (If rural, give location) <u>530 W. Montg. Ave.</u>			
3. NAME OF DECEASED:		(First)		(Middle)		(Last)	
(Type or Print) <u>WILLIAM</u>		<u>A.</u>		<u>FLING</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>widowed</u>		<u>May 28, 1892</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Ret.</u>		<u>Laundrey-Self Emp.</u>		<u>Virginia</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Wm. F. Fling</u>				<u>Martha A. Walker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>yes</u>		<u>Harvey Fling-RFD # 1 Rockville, Md.</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause		(a) — <u>Crown Occlusion</u>			
Antecedent cause(s)		DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(b) — <u>Hypertensive Cardio Vascular Disease.</u>		<u>20 yr.</u>	
DUE TO		(c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Liver & Portal Obstruction</u>					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>John S. Ball</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Jan. 8, 1956</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>1-11-56</u>		<u>Forest Oak</u>	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR		ADDRESS	
<u>Gaithersburg, Md.</u>		<u>Samuel St. Hughes</u>		<u>Bethesda, Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			
<u>1/9/56</u>		<u>Robert M. Humphrey</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOTED BY THE BUREAU OF HEALTH - BALTIMORE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DEATH (Last, first and middle names) (If the name is not known, give the name of the person who was with the deceased at the time of death)		2. PLACE OF DEATH (City, town or village) (If the place is not known, give the name of the person who was with the deceased at the time of death)	
3. SEX (Male or Female)		4. COLOR OR RACE (White, Black, Brown, Yellow, Red, etc.)	
5. AGE (In years, months and days) (If the age is not known, give the date of birth)		6. DATE OF BIRTH (Month, day and year)	
7. OCCUPATION (If the occupation is not known, give the name of the person who was with the deceased at the time of death)		8. MARRIAGE (Single, Married, Widowed, Divorced, etc.)	
9. EDUCATION (If the education is not known, give the name of the person who was with the deceased at the time of death)		10. RELIGION (If the religion is not known, give the name of the person who was with the deceased at the time of death)	
11. PHYSICAL CONDITION (If the physical condition is not known, give the name of the person who was with the deceased at the time of death)		12. MENTAL CONDITION (If the mental condition is not known, give the name of the person who was with the deceased at the time of death)	
13. CAUSE OF DEATH (If the cause of death is not known, give the name of the person who was with the deceased at the time of death)		14. MANNER OF DEATH (If the manner of death is not known, give the name of the person who was with the deceased at the time of death)	
15. SIGNATURE OF EXAMINER (If the signature is not known, give the name of the person who was with the deceased at the time of death)		16. DATE OF DEATH (Month, day and year)	

BUREAU W.S.S.

JAN 11 1915

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

781

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00741

CERTIFICATE OF DEATH

Reg. Dist. No.

216

Items 11, 12, 13, 14, Film 192 2-2-56 et Items 3, 11, 13, 14, Film 192 2-20-56 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Bethesda</u>	<u>5 days</u>	TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural give location) <u>6408 Russin Road</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Edith</u>	(Middle) <u>B.</u>	(Last) <u>Foster</u>	OF DEATH: <u>Jan. 26</u> 19 <u>56</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Feb. 8, 1877</u>
		9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
		<u>Wyoming, Illinois</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Unknown John Whitcher</u>		<u>Alma Hall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Acute Pulmonary Embolism</u>		<u>1 hr</u>
ANTECEDENT CAUSE (S) (B) <u>Chronic Pneumonia</u>		<u>6 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cerebral Vascular Accident</u>		<u>3 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 18, 1956, to Jan. 26, 1956, that I last saw the deceased alive on Jan. 26, 1956, and that death occurred at 1:00 P.M., from the causes and on the date stated above.

SIGNATURE <u>Edith B. Gossain</u>	ADDRESS <u>M. D. 3921, Longwood St. N.W. Wash. D.C.</u>	DATE SIGNED <u>2-6-56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/30/1956</u>	NAME OF CEMETERY OR CREMATORY <u>Georgetown, Illinois</u>
LOCATION (City, town, or county) (State)	24. FUNERAL DIRECTOR <u>Martin W. Lyson</u>	ADDRESS <u>300 N. 1st St. N.W.</u>
DATE REC'D BY LOCAL REGISTRAR <u>1/28/56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED

JAN 31 1956

BUREAU V. S.

782

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00742

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring
 TOWN Silver Spring
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 924-Sligo Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE D. C. COUNTY Washington
 CITY (If outside corporate limits, write RURAL and give nearest town) Washington
 TOWN 47X-3
 STREET ADDRESS (If rural give location) 5422 Nevada Ave NW

3. NAME OF DECEASED:

(First) Gertrude

(Middle)

(Last) Fox

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Jan. 12 19 56

5. SEX:

Female

6. COLOR OR RACE:

White7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH:

11-6-1879

9. AGE last birthday:

76 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life even if retired:

Retired School Teacher

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

New Haven Conn

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Timothy J Fox

14. MOTHER'S MAIDEN NAME:

Theresa Healy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

No

17. INFORMANT & ADDRESS:

Mrs Frederick

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

Immediate cause

(a) Pulmonary edema

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Myocardial failure

DUE TO

(c) Generalized arteriosclerosis, severe

Interval Between Onset And Death

72 hours2 months3 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Gastro-intestinal atony4 months

19a. DATE OF OPERATION:

0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 15, 1954, to Jan 12, 1956, that I last saw the deceasedalive on Jan 11, 1956, and that death occurred at 4 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Anna C. Hendon, M.D.3935 Baltimore St., Kensington, Md.1/12/56

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-12-56Francis PotterThe S. H. Howe Co. 3801-4 St. N.W.Washington D.C.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 16 1950

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		56	
TOWN <u>Bethesda</u>		<u>6 days</u>		TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Resmar 5721 GROVE NOR RANE 8912 Walden Rd.</u>				STREET ADDRESS (If rural give location) <u>8912 Walden Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>Russie</u> - <u>Fay</u>				<u>Jan. 8 1956</u>			
5. SEX:	6. COLOR OR RACE	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days Hours Min.		
<u>F</u>	<u>W</u>	<u>married</u>	<u>Sept. 17, 1892</u>	<u>63 yrs.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>	
<u>Housewife</u>				<u>Poland</u>		<u>Poland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Hyman Gordon</u>				<u>Israh E. Isberg</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>-</u>		<u>Philip Townsend - 9523 - Saybrook ave S.S. Ind</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>acute lobar pneumonia</u>			<u>3 days</u>
ANTECEDENT CAUSE (S) (B) <u>Pyelonephritis - Cystitis</u>			<u>3 weeks</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Urinary Incontinence</u>			<u>6 weeks</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebrovascular Accident</u>			<u>7 weeks</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov 20, 1955 to Jan 8, 1956 that I last saw the deceased alive on Jan 8, 1956, and that death occurred at 3:42 M. from the causes and on the date stated above.

SIGNATURE <u>Benjamin Manchester</u>	M.D. <u>3200-16 St NW - Wash. D.C.</u>	DATE SIGNED <u>Jan 8, 1956</u>
23. BURIAL CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>1/8/56</u>	<u>B'nai Israel</u>
LOCATION (City, town, or county)	(State)	
<u>Open Hill</u>	<u>Ind</u>	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>1/9/56</u>	<u>Bessie M. Thompson</u>	<u>Leahing Funeral Home</u>
		ADDRESS <u>4217 9th Ave</u>

MARGIN RESERVED FOR BINDING

RECEIVED

JAN 11 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 01915
Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Bethesda</u>		<u>10 day</u>		TOWN <u>Gaithersburg</u> <u>R70</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp</u>				STREET ADDRESS (If rural, give location) <u>Metropolitan Grove</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Elizabeth</u>				<u>June 31 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED:	8. DATE OF BIRTH:	9. AGE last birthday:		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
<u>Female</u>	<u>Colored</u>	<u>Married</u>	<u>April 25, 1895</u>	<u>60</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housekeeper</u>				<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Moore</u>				<u>Elizabeth unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
				<u>Bradley P. Bates - Gaithersburg, Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Shock</u> Antecedent cause(s) (b) <u>1st & 2nd degree burns involving arms, neck and back</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)						<u>10 day</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)			
		<u>Home</u>		<u>Gaithersburg Montg md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>15</u> <u>2-21-56</u> <u>5:45 P.M.</u>				<u>Home caught fire & burned</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>Frank J. Brochant</u>						<u>2-1-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-4-56</u>		<u>Brownstown</u>		<u>Germantown, Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2-6-56</u>		<u>Bessie M. Thompson</u>		<u>Robert K. Snowden - Rockville</u>		<u>Md</u>	

RECEIVED

FEB 9 1956

BUREAU V. S.

1

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this, certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

735

CERTIFICATE OF DEATH

00744

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Silver Spring</u>				TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1528 Grace Church Road</u>				STREET ADDRESS (If rural give location) <u>1528 Grace Church Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Rosalind</u> <u>Friaard</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 22, 1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>June 4, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John D. Dally</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alice Hines</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Dorothy F. Riley- Daughter</u> <u>1528 Grace Church Road, S.S. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease with acute congestive failure and terminal hypostatic pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>_____</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>_____</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Carcinoma both lungs with extensive metastasis into the thoracic cage, primary both breasts</u>						6 years	
19a. DATE OF OPERATION <u>April 4, 1950</u>		19b. MAJOR FINDINGS OF OPERATION <u>& June 1, 1950: Bilateral mastectomy</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 3, 1950</u> , to <u>Jan. 22, 1956</u> , that I last saw the deceased alive on <u>Jan. 22, 1956</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. Country</u>				DATE SIGNED <u>5601-4 at Washington D.C. 1/25/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. REC'D BY REGISTRAR <u>1/25/56</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The S. N. Hines Co.</u> ADDRESS <u>2901 14th St., N.W. Washington, D.C.</u>			

CERTIFICATE OF DEATH

73

PLACE OF DEATH HOME		COUNTY BALTIMORE	
STREET 1234 GUYTON STREET		CITY BALTIMORE	
STATE MARYLAND		ZIP CODE 21201	
DECEASED JOHN J. SMITH		SEX MALE	
DATE OF BIRTH JAN 15 1900		AGE 56	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH BALTIMORE		DATE OF DEATH JAN 27 1956	
SIGNATURE OF DECEASED (Blank)		SIGNATURE OF WITNESS (Blank)	
SIGNATURE OF PHYSICIAN (Blank)		SIGNATURE OF CORONER (Blank)	
SIGNATURE OF MINISTER (Blank)		SIGNATURE OF CLERGYMAN (Blank)	
SIGNATURE OF BURIAL OFFICER (Blank)		SIGNATURE OF HEALTH OFFICER (Blank)	

BUREAU V. 51

JAN 27 1956

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

736

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00745

Item 8, Film G191 1-24-56 et

Reg. Dist. No. 218

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montg</u>		STATE <u>Maryland</u>		COUNTY <u>Montg</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Gaithersburg</u>		<u>60yrs</u>		TOWN <u>Gaithersburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Charley Elmer Gartner</u>				<u>Jan 15 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Jan 7-1882</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer. Farm</u>		<u>Machine Man</u>		<u>Ohio</u>		<u>U S A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Jacob T. Gartner</u>				<u>Florence Staley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Robert Gartner. Gaithersburg, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Acute Cardiac Failure</u>						<u>12 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Paralytic Agitation</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 30</u>, 19<u>55</u>, to <u>Jan 15</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Jan 15</u>, 19<u>56</u>, and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. J. Brozant</u>				ADDRESS (Street, city, town, state) <u>Gaithersburg Md</u>		DATE SIGNED <u>1-16-56</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 17-56</u>		<u>Forest Oak</u>		<u>Gaithersburg Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan 17-56</u>		<u>Alfred S. Cook</u>		<u>Ernest C. Gartner, Gaithersburg, Md.</u>			

RECEIVED

JAN 18 1956

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [REDACTED]
2. SEX: [REDACTED] 3. AGE: [REDACTED] 4. DATE OF BIRTH: [REDACTED]
5. PLACE OF BIRTH: [REDACTED] 6. OCCUPATION: [REDACTED]
7. MARITAL STATUS: [REDACTED] 8. PRESENT RESIDENCE: [REDACTED]
9. DATE OF DEATH: [REDACTED] 10. TIME OF DEATH: [REDACTED]
11. PLACE OF DEATH: [REDACTED] 12. CAUSE OF DEATH: [REDACTED]
13. MEDICAL EXAMINATION: [REDACTED] 14. SIGNATURE OF PHYSICIAN: [REDACTED]
15. SIGNATURE OF REGISTRAR: [REDACTED] 16. SIGNATURE OF WITNESSES: [REDACTED]
17. SIGNATURE OF DECEASED: [REDACTED] 18. SIGNATURE OF NEXT OF KIN: [REDACTED]
19. SIGNATURE OF CLERGYMAN: [REDACTED] 20. SIGNATURE OF BURIAL OFFICIAL: [REDACTED]
21. SIGNATURE OF FUNERAL HOME: [REDACTED] 22. SIGNATURE OF CEMETERY: [REDACTED]
23. SIGNATURE OF INTERVIEWER: [REDACTED] 24. SIGNATURE OF SUPERVISOR: [REDACTED]
25. SIGNATURE OF ASSISTANT SUPERVISOR: [REDACTED] 26. SIGNATURE OF CLERK: [REDACTED]
27. SIGNATURE OF RECEPTIONIST: [REDACTED] 28. SIGNATURE OF TELEPHONE OPERATOR: [REDACTED]
29. SIGNATURE OF MAIL ROOM: [REDACTED] 30. SIGNATURE OF RECORDS SECTION: [REDACTED]
31. SIGNATURE OF STATISTICS SECTION: [REDACTED] 32. SIGNATURE OF LABORATORY: [REDACTED]
33. SIGNATURE OF RADIOLOGY: [REDACTED] 34. SIGNATURE OF PATHOLOGY: [REDACTED]
35. SIGNATURE OF BACTERIOLOGY: [REDACTED] 36. SIGNATURE OF VIROLOGY: [REDACTED]
37. SIGNATURE OF IMMUNOLOGY: [REDACTED] 38. SIGNATURE OF EPIDEMIOLOGY: [REDACTED]
39. SIGNATURE OF PUBLIC HEALTH: [REDACTED] 40. SIGNATURE OF NURSING: [REDACTED]
41. SIGNATURE OF DENTISTRY: [REDACTED] 42. SIGNATURE OF OPTOMETRY: [REDACTED]
43. SIGNATURE OF PODIATRY: [REDACTED] 44. SIGNATURE OF PHYSICIAN ASSISTANT: [REDACTED]
45. SIGNATURE OF NURSE: [REDACTED] 46. SIGNATURE OF LABORATORY ASSISTANT: [REDACTED]
47. SIGNATURE OF RADIOLOGY ASSISTANT: [REDACTED] 48. SIGNATURE OF PATHOLOGY ASSISTANT: [REDACTED]
49. SIGNATURE OF BACTERIOLOGY ASSISTANT: [REDACTED] 50. SIGNATURE OF VIROLOGY ASSISTANT: [REDACTED]
51. SIGNATURE OF IMMUNOLOGY ASSISTANT: [REDACTED] 52. SIGNATURE OF EPIDEMIOLOGY ASSISTANT: [REDACTED]
53. SIGNATURE OF PUBLIC HEALTH ASSISTANT: [REDACTED] 54. SIGNATURE OF NURSING ASSISTANT: [REDACTED]
55. SIGNATURE OF DENTISTRY ASSISTANT: [REDACTED] 56. SIGNATURE OF OPTOMETRY ASSISTANT: [REDACTED]
57. SIGNATURE OF PODIATRY ASSISTANT: [REDACTED] 58. SIGNATURE OF PHYSICIAN ASSISTANT ASSISTANT: [REDACTED]
59. SIGNATURE OF NURSE ASSISTANT: [REDACTED] 60. SIGNATURE OF LABORATORY ASSISTANT ASSISTANT: [REDACTED]
61. SIGNATURE OF RADIOLOGY ASSISTANT ASSISTANT: [REDACTED] 62. SIGNATURE OF PATHOLOGY ASSISTANT ASSISTANT: [REDACTED]
63. SIGNATURE OF BACTERIOLOGY ASSISTANT ASSISTANT: [REDACTED] 64. SIGNATURE OF VIROLOGY ASSISTANT ASSISTANT: [REDACTED]
65. SIGNATURE OF IMMUNOLOGY ASSISTANT ASSISTANT: [REDACTED] 66. SIGNATURE OF EPIDEMIOLOGY ASSISTANT ASSISTANT: [REDACTED]
67. SIGNATURE OF PUBLIC HEALTH ASSISTANT ASSISTANT: [REDACTED] 68. SIGNATURE OF NURSING ASSISTANT ASSISTANT: [REDACTED]
69. SIGNATURE OF DENTISTRY ASSISTANT ASSISTANT: [REDACTED] 70. SIGNATURE OF OPTOMETRY ASSISTANT ASSISTANT: [REDACTED]
71. SIGNATURE OF PODIATRY ASSISTANT ASSISTANT: [REDACTED] 72. SIGNATURE OF PHYSICIAN ASSISTANT ASSISTANT: [REDACTED]
73. SIGNATURE OF NURSE ASSISTANT ASSISTANT: [REDACTED] 74. SIGNATURE OF LABORATORY ASSISTANT ASSISTANT: [REDACTED]
75. SIGNATURE OF RADIOLOGY ASSISTANT ASSISTANT: [REDACTED] 76. SIGNATURE OF PATHOLOGY ASSISTANT ASSISTANT: [REDACTED]
77. SIGNATURE OF BACTERIOLOGY ASSISTANT ASSISTANT: [REDACTED] 78. SIGNATURE OF VIROLOGY ASSISTANT ASSISTANT: [REDACTED]
79. SIGNATURE OF IMMUNOLOGY ASSISTANT ASSISTANT: [REDACTED] 80. SIGNATURE OF EPIDEMIOLOGY ASSISTANT ASSISTANT: [REDACTED]
81. SIGNATURE OF PUBLIC HEALTH ASSISTANT ASSISTANT: [REDACTED] 82. SIGNATURE OF NURSING ASSISTANT ASSISTANT: [REDACTED]
83. SIGNATURE OF DENTISTRY ASSISTANT ASSISTANT: [REDACTED] 84. SIGNATURE OF OPTOMETRY ASSISTANT ASSISTANT: [REDACTED]
85. SIGNATURE OF PODIATRY ASSISTANT ASSISTANT: [REDACTED] 86. SIGNATURE OF PHYSICIAN ASSISTANT ASSISTANT: [REDACTED]
87. SIGNATURE OF NURSE ASSISTANT ASSISTANT: [REDACTED] 88. SIGNATURE OF LABORATORY ASSISTANT ASSISTANT: [REDACTED]
89. SIGNATURE OF RADIOLOGY ASSISTANT ASSISTANT: [REDACTED] 90. SIGNATURE OF PATHOLOGY ASSISTANT ASSISTANT: [REDACTED]
91. SIGNATURE OF BACTERIOLOGY ASSISTANT ASSISTANT: [REDACTED] 92. SIGNATURE OF VIROLOGY ASSISTANT ASSISTANT: [REDACTED]
93. SIGNATURE OF IMMUNOLOGY ASSISTANT ASSISTANT: [REDACTED] 94. SIGNATURE OF EPIDEMIOLOGY ASSISTANT ASSISTANT: [REDACTED]
95. SIGNATURE OF PUBLIC HEALTH ASSISTANT ASSISTANT: [REDACTED] 96. SIGNATURE OF NURSING ASSISTANT ASSISTANT: [REDACTED]
97. SIGNATURE OF DENTISTRY ASSISTANT ASSISTANT: [REDACTED] 98. SIGNATURE OF OPTOMETRY ASSISTANT ASSISTANT: [REDACTED]
99. SIGNATURE OF PODIATRY ASSISTANT ASSISTANT: [REDACTED] 100. SIGNATURE OF PHYSICIAN ASSISTANT ASSISTANT: [REDACTED]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

737

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

00746

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY Montgomery		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) Kensington		CITY (If outside corporate limits, write RURAL and give nearest town) Kensington	
TOWN Kensington		TOWN Kensington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3108 Ferndale Street		STREET ADDRESS (If rural, give location) 3108 Ferndale Street	
3. NAME OF DECEASED (First) (Middle) (Last) JOHN EARLY GATEWOOD		4. DATE OF DEATH (Month) (Day) (Year) JANUARY 15 1956	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Oct. 4, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer-General Services Admr.		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 52 yrs.
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Gatewood		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes--Card lost	
17. INFORMANT AND ADDRESS Mrs. Dorothy L. Gatewood, Kensington, Md.		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (a) Coronary occlusion (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden death	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE Frank J. Broschart M.D.		DATE SIGNED 1-15-56	
23. BURIAL, CREMATION, REMOVAL (Specify) Trans. & Burial		DATE THEREOF 1/16/56	
LOCATION (City, town, or county) The New Cemetery		(State) Spray, North Carolina	
DATE REC'D BY LOCAL REG. 1-16-56		REGISTRAR'S SIGNATURE Frances Potter	
24. FUNERAL DIRECTOR Wanner E. Humphrey		ADDRESS Silver Spring, Md.	

RECEIVED

JAN 18 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write and give nearest town)			
17 TOWN <u>Fortoma Pk.</u>		3 mo-9 days		TOWN <u>Silver Spring</u>		56	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
75 <u>Washington San & Hosp.</u>				10812 Lorain Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Lucy Anna Giacofei</u>				<u>January 17 1956</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>widowed</u>		<u>11-11-86</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>69</u> yrs.		<u>Months</u>		<u>Days</u>		<u>Hours</u> <u>Min.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>house wife</u>				<u>none</u>		<u>Austria</u>	
13. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
<u>Joseph Babich</u>				<u>United States</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
						<u>Wm. J. Giacofei - 10812 Lorain Ave.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Carcinomatous</u>		
ANTECEDENT CAUSE (S) DUE TO (B) <u>Carcinoma of Ovary</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 54</u> , 19 <u>54</u> , to <u>Jan 56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 16</u> , 19 <u>56</u> , and that death occurred at <u>4:30</u> P. M., from the causes and on the date stated above.					
SIGNATURE <u>Bernard A. Jutzewski</u>		ADDRESS <u>M. D. 9620 Old Bladenburg Rd</u>		DATE SIGNED <u>1-17-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATION	
<u>Burial</u>		<u>1-20-56</u>		<u>Beacon Hill Cemet</u>	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR		ADDRESS	
<u>M.D.</u>		<u>Robert H. Matheney</u>		<u>131</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		ADDRESS	
<u>Jan 18 1956</u>		<u>J. Nelson Decker</u>		<u>8 E</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 19 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Rockville Rural LENGTH OF STAY (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Circle Dr. Glen Hills RFD #1

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) Rockville Rural
 STREET ADDRESS (If rural, give location) Circle Dr. Glen Hills RFD #1

3. NAME OF DECEASED:

(First) MARY (Middle) PENNINGTON (Last) GOVER
 (Type or Print)

4. DATE OF DEATH: Jan. 17 19 56
 (Month) (Day) (Year)

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

widowed

8. DATE OF BIRTH:

5-30-1873

9. AGE last birthday:

82

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months 7 Days 17 Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

Home

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Charles O. Pennington

14. MOTHER'S MAIDEN NAME:

Hannah Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

No

None

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Son S. Clark Gover
 Circle Dr. Glen Falls RFD #1 Rockville

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Congestive heart failure

INTERVAL BETWEEN ONSET AND DEATH

4 mos.

Antecedent cause(s)

(b)

DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

Generalized arteriosclerosis

30 yrs.

(c)

Sensitivity

10 yrs.

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1955, to 1/17, 1956, that I last saw the deceased alive on 1/15, 1956, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 1/23/56

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Laurel H. Grayson

Robert A. Humphrey

Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 24 1956

RECEIVED

739

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

COUNTY Montgomery

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Rural-Rockville

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

6305 Tilden Lane

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Rural-Rockville

STREET ADDRESS (If rural give location)

6305 Tilden Lane

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

JOHN WILSON GREEN

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Jan. 10, 1956

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MaleWhiteMarriedOct. 1, 190154 yrs.2 Months9 Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Furniture Upholstering

10B. KIND OF BUSINESS OR INDUSTRY:

Self Emp.

11. BIRTHPLACE (State or foreign country):

Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

John H. Green

14. MOTHER'S MAIDEN NAME:

Elzida McCeasky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Cecile A. Green-Item# 2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

Instant10 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐

M.

at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 4, 1956, to Jan 10, 1956, that I last saw the deceasedalive on Jan 4, 1956 and that death occurred at 6 P. M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

M.D. 1016Rockville, Md.1/11/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial1-13-56ParklawnRockville, Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

1/12/56Bessie M. ThompsonRobert A. ThompsonBethesda, Md.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 16 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11, Film G191 1-16-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

00750

223

713

1. PLACE OF DEATH: <u>EVENTIDE NURSING HOME</u> <u>700 HUDSON AVENUE</u> COUNTY <u>MONTGOMERY CTY. MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: <u>8501 LYNWOOD PLACE CHEVY CHASE MD.</u> STATE <u>MD.</u> COUNTY <u>MONTGOMERY.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TAKOMA PARK</u> LENGTH OF STAY (in this place) <u>2 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CHEVY CHASE MD.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EVENTIDE NURSING HOME.</u>		STREET ADDRESS (If rural give location) <u>8501 LYNWOOD PL.</u>	
3. NAME OF DECEASED: (First) <u>MARY</u> (Middle) <u>ISABEL</u> (Last) <u>GREEN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>JAN.</u> <u>7</u> <u>1956</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOW</u>	8. DATE OF BIRTH: <u>1864</u>
9. AGE last birthday <u>91</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country): <u>EASTERN SHORE OF MARYLAND.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>HESSEY</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Louise Anthony</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE.</u>	
17. INFORMANT & ADDRESS: <u>MRS. PATRICIA GREEN ROGERS.</u> <u>8501 LYNWOOD PL. CHEVY CHASE, MD.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>			<u>FEW SECONDS.</u>
ANTECEDENT CAUSE (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>			<u>30 YRS.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>490X</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>RECENT LOBAR PNEUMONIA</u>			<u>1 MONTH</u>
19A. DATE OF OPERATION: <u>NONE</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>DEC. 11, 1955</u> , to <u>JAN. 6, 1956</u> , that I last saw the deceased alive on <u>JAN. 6, 1956</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Joseph P. Connor</u>		ADDRESS <u>BETHESDA, MD.</u> DATE SIGNED <u>7 Jan. 1956</u>	
M. D. <u>9600 OLD GEORGETOWN RD.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-9-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Centerville Md</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 7 1956</u>		REGISTRAR'S SIGNATURE <u>Joseph P. Connor</u>	
24. FUNERAL DIRECTOR <u>Joseph Hawley's Sons</u>		ADDRESS <u>Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 10 1956

RECEIVED

790
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>Dist. Col.</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u> 474-9			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp -</u>				STREET ADDRESS (If rural give location) <u>4641 Greene Pl. N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mary Alice Greene</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>Jan. 14 1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>Oct. 14, 1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Louden Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Josephus Hospital</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Catherine Costello</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. W^m C. Hazel, daughter (same)</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>							
ANTECEDENT CAUSE (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/14</u> , 19 <u>56</u> , to <u>1/14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/14</u> , 19 <u>56</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Andrew 2. Anderson</u>		ADDRESS <u>5120 MacArthur Blvd.</u>		DATE SIGNED <u>1/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Leesburg, Virginia.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-16-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Joseph F. Birch's Son, D.C.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. S.

JAN 18 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223...

716

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Takoma Park</u>		<u>12nd</u> <u>8 days</u>		TOWN <u>Takoma Park</u>		<u>12th</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San and Hosp 7600 Carroll Ave</u>				STREET ADDRESS (If rural give location) <u>Takoma Park</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>May</u> <u>Greer</u>				<u>Jan</u> <u>29</u> <u>1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>white</u>	<u>Widow</u>	<u>2-23-78</u>	<u>77</u> yrs.	<u>11</u> Months <u>11</u> Days	<u>11</u> Hours <u>11</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Employee</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Indiana</u>	
13. FATHER'S NAME: <u>Henderson Mrs Jonathan</u>				14. MOTHER'S MAIDEN NAME: <u>Miller Mrs Mary</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>Washington San and Hosp</u> <u>Washington</u> <u>12th</u> <u>7600 Carroll Ave Takoma Park</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Coronary Occlusion</u>						<u>Terminal</u>	
(B) <u>Hypertension</u>						<u>Unknown</u>	
(C) <u>Arteriosclerosis</u>						<u>Unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-21</u> , 1956, to <u>1-29</u> , 1956 that I last saw the deceased alive on <u>1-29</u> , 1956, and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert A. Hare</u>				ADDRESS <u>M. D. Takoma Park, Md</u>		DATE SIGNED <u>1/29/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 17 1956</u>		<u>Rock Creek Cem</u>		<u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>2901 14th St</u> <u>Washington D.C.</u>			
<u>1-29-1956</u>		<u>Robert A. Hare</u>		<u>A.H. Harris Co.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED THE DEPT. OF COMMERCE

RECEIVED THE DEPT. OF COMMERCE

BUREAU V. S.

FEB 2 1936

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

791
CERTIFICATE OF DEATHReg. Dist. No. 00753
216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Bethesda</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Resmor Sanitarium 5721 Grosvenor Lane</u>				STREET ADDRESS (If rural give location) <u>4402 Winston Dr.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		5. SEX:		6. COLOR OR RACE:	
Blanche Grillo		Jan. 25 1956		F		W	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:		9. AGE last birthday		IF UNDER 1 YEAR	
Widowed		Feb. 17, 1875		80 yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Cincinnati Ohio		U.S.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Samuel Bolles				Sarah Bosworth			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		No		Records at Sanitarium			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma, ovary ± widespread metastases</u> 18 MOS							
ANTECEDENT CAUSE (S) DUE TO <u>left</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>(confirmed by PAP smear)</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>arteriosclerotic heart disease</u> 20 YRS							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
none							
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCT.</u> , 19 <u>55</u> , to <u>present</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/25</u> , 19 <u>56</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Charles J. Savarese, Jr.</u>		<u>1/27/56</u>		<u>7th Lincoln Cem</u>		<u>Prince Georges Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-25-56</u>		<u>Beverly M. Thompson</u>		<u>The Stokes Co</u>		<u>2901-14th St. N.W. Washington D.C.</u>	

RECEIVED

JAN 30 1956

BUREAU V. S.

792

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00754

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montg.	
CITY (If outside corporate limits, write RURAL and give nearest town) Rural - Woodfield		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Rural - Woodfield			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D. # 1 Gaithersburg				STREET ADDRESS (If rural give location) R.F.D. #1 Gaithersburg			
3. NAME OF DECEASED: (First) (Middle) (Last) Samuel Floyd Grimes				4. DATE OF DEATH: (Month) (Day) (Year) Jan. 17 19 56			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: Dec. 5, 1894	
				9. AGE last birthday: 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired Retired Building Contractor				10b. KIND OF BUSINESS OR INDUSTRY: Montg. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Samuel T. Grimes				14. MOTHER'S MAIDEN NAME: Annie Jane Beall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mrs Bertie W. Grimes, Gaithersburg, Md.			
18. MEDICAL CERTIFICATION				Interval Between Onset And Death			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) Hypertensive - Cardio - Vascular				Months			
Antecedent causes (s) (b) Renal disease as manifested by acute left ventricular failure				20 years			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar. 1954 , to Jan. 17, 1956 , that I last saw the deceased alive on Jan. 17, 1956 , and that death occurred at 11:05 PM ; from the causes and on the date stated above.							
SIGNATURE Jack Schumacher M.D.		(Degree or title)		ADDRESS Gaithersburg, Md.		DATE SIGNED Jan. 18 56	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Jan. 20, 1956		Wesley Grove		Woodfield, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
Jan. 19, 1956		Della W. Burdette		Olin L. Molesworth, Damascus, Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JAN 28 1956

RECEIVED

John L. Roberts, Jr., Attorney at Law, New York, N.Y.

John L. Roberts, Jr., Attorney at Law, New York, N.Y.

793

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 18 days		CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring		56	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 12122 Selfridge Road		1	
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) Lyman		(Middle) Walter		(Last) GUILFORD		DATE OF DEATH: January 9 19 56	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 4-26-92	
9. AGE last birthday 63 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman				10B. KIND OF BUSINESS OR INDUSTRY: Retail		11. BIRTHPLACE (State or foreign country): Iowa	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME: William GUILFORD				14. MOTHER'S MAIDEN NAME: Maude E. ALLEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes (If Yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Wife Mrs. Nannamal GUILFORD same as above	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.0 IMMEDIATE CAUSE (A) Congestive failure		undef.
ANTECEDENT CAUSE (S) DUE TO (B) ASHD & Myocardial infarction		undef.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Coronary occlusion		undef.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Lobar pneumonia		undef.

19A. DATE OF OPERATION: 2	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **9 Jan 19 56**, to **9 Jan 19 56**, that I last saw the deceased **alive on 9 Jan 19 56** and that death occurred at **8:20A**, from the causes and on the date stated above.

SIGNATURE **B. S. Furick LTJG, MC, USNR U. S. Naval Hospital, NMMC, Bethesda, Maryland** ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12 Jan 56	Arlington National Cemetery	Arlington, Virginia

DATE REC'D BY LOCAL REGISTRAR 10 Jan 1956	REGISTRAR'S SIGNATURE Mary E. Canally	24. FUNERAL DIRECTOR'S ADDRESS Chambers Funeral Home 517 11th Street, S.E. Washington, D.C.
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MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 16 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00756

794

CERTIFICATE OF DEATH

Reg. Dist. No. 216...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY MONTGOMERY	MARYLAND	STATE N.C.	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN SUMNER HIGHLAND APT.	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN DUNN	70 x -3
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 4513 SANGAMORE RD.		STREET ADDRESS ROUTE #4	
3. NAME OF DECEASED: (Type or Print) SARAH E HAMILTON		4. DATE (Month) (Day) (Year) OF DEATH: 1 19 1956	
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): WIDOWED	8. DATE OF BIRTH: 6/22/1869
9. AGE last birthday 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE	11. BIRTHPLACE (State or foreign country): NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME: RANDALL SMITH	
14. MOTHER'S MAIDEN NAME: ? MATHEWS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO NONE	
16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: MRS VAUGHAN 6524-79th ST. CABIN JOHN, MD.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 420.1			
ANTECEDENT CAUSE (S) acute coronary thrombosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Hypertension			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 5 to Jan. 19, 1956 , that I last saw the deceased alive on Jan. 19, 1956 , and that death occurred at 11:15 M. from the causes and on the date stated above.			
SIGNATURE Andrew E. Medusai		ADDRESS 1720 Woodlawn Dr. N.W.	
DATE SIGNED 1/20/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 1/21/56	
NAME OF CEMETERY OR CREMATORY GREENWOOD CEM.		LOCATION (City, town, or county) DUNN, N.C.	
DATE REC'D BY LOCAL REGISTRAR 1-20-56		REGISTRAR'S SIGNATURE Barrie M. Thompson	
FUNERAL DIRECTOR The S. H. Hines Co		ADDRESS 2701-14th St. N.W. Washington, D.C.	

BUREAU V. S.

JAN 23 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington (23)</u>		<u>16X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>National Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>4603 Lewis Ave.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>Ernest</u>		(Middle) <u>-</u>		(Last) <u>Hancock</u>		(Month) <u>1</u> (Day) <u>2</u> (Year) <u>1956</u>	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>		8. DATE OF BIRTH: <u>Oct 14, 1890</u>	
9. AGE last birthday: <u>65</u> yrs.		10. MONTHS <u>1</u> DAYS <u>2</u> HOURS <u>19</u> MIN.		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>caretaker</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Cemetery</u>			
13. FATHER'S NAME: <u>Robert Hancock</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Caywood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY No.: <u>5 770 79743</u>		17. INFORMANT & ADDRESS: <u>Patient on admission</u>	

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
203X Immediate cause		(a) <u>Anuria and hypotension - unknown cause</u>		<u>days</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		(b) <u>Myeloma, Multiple</u>		<u>4 months</u>	
		(c)			
11. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death. <u>bilateral lower lobe broncho pneumonia</u>				<u>days</u>	
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11/1</u> , 19 <u>55</u> , to <u>1/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/2</u> , 19 <u>56</u> , and that death occurred at <u>11:10 AM</u> , from the causes and on the date stated above.					
SIGNATURE <u>Hubert G. Jones Jr.</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>N.C.I Bethesda, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>Jan 4-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
LOCATION (City, town, or county) <u>Southland Maryland</u>		(State) <u>Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>1/3/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Simmons Bros</u>	
				ADDRESS <u>1661 - good hope rd SE Wash, DC</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) 12th & Park LENGTH OF STAY (in this place) 38 hrs.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. Sanatorium & Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56
 TOWN Silver Spring (If rural, give location)
 STREET ADDRESS 8009 Piney Branch Rd.

3. NAME OF DECEASED:

(First) Mabel (Middle) Muriel (Last) Hannah

4. DATE OF DEATH: (Month) 1 (Day) - 17 (Year) 1956

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday: (If under 1 year) (If under 24 hrs.)
 Months 83 Days 83 Hours 83 Min. 83

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

George W. W. W.

14. MOTHER'S MAIDEN NAME:

Adelaide Gregory

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, in or out) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.: —

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) Cerebral hemorrhage

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Hypertension

DUE TO

(c) Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

21 hrs

Indefinite

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
 INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE

Edmund L. Burnett, M.D. (DEGREE OR TITLE) ADDRESS 7701-Carroll Ave. Takoma Park Md.

DATE SIGNED

11/17/56

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Fun. 17-1956 J. Wilson Rodde Deaf Funeral Home 4812 Pa Ave Washington D.C.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 19 1956

RECEIVED

713

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>—</u>		COUNTY <u>— 47X-3</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>17 Ikoma Park</u>		<u>31 days</u>		OR TOWN <u>District of Columbia</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>25 Wash. Sanatorium & Hospital</u>				STREET ADDRESS (If rural give location) <u>1930 Columbia Rd. N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Fred Bernard Harper.</u>				OF DEATH: <u>1 - 20 1956</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>Caucasian</u>		<u>Single</u>		<u>1-16-90</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday		IF UNDER 1 YEAR	
<u>Broker.</u>		<u>Invest. Broker</u>		<u>66</u> yrs.		Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>D.C.</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>James Harper.</u>				<u>Lavinia Baeschlin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<u>Yes.</u>				<u>W.W.</u>		<u>Hospital Records</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
610 X IMMEDIATE CAUSE (A) <u>Post-operative haemorrhage (Transurethral Prostatectomy)</u>		
ANTECEDENT CAUSE (S) (B) <u>AFIBRINOGENAEMIA</u>		<u>18 hours.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
<u>Cerebro Vascular Accident</u>		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>1.19.56</u>	<u>Prostatic Hypertrophy.</u>	

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>11/10</u> , 19 <u>55</u> , to <u>1/20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/19</u> , 19 <u>56</u> , and that death occurred at <u>4:40 A.M.</u> , from the causes and on the date stated above.	
SIGNATURE <u>Herbert A. Goldberg</u>	DATE SIGNED <u>1-20-56</u>

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Buried</u>	<u>1/23/56</u>	<u>Mt. Olivet</u>	<u>Washington, D.C.</u>

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Jan-20-1956</u>	<u>William Dodd</u>	<u>Francis Collins</u>	<u>3821 74 St NW</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 23 1956

RECEIVED

796

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Fairfax</u>	
CITY (If outside corporate limits, write TOWN and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>29 days</u>		CITY (If outside corporate limits, write TOWN and give nearest town) <u>Herndon</u>		<u>83X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u>				STREET ADDRESS (If rural give location) <u>Route # 2</u>			
50							
3. NAME OF DECEASED: (Type or Print)		(First) <u>Stephen</u>		(Middle) <u>Olden</u>		(Last) <u>Harrison</u>	
4. DATE OF DEATH: (Month) <u>January</u> (Day) <u>20</u> (Year) <u>1956</u>							
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>May 17, 1954</u>	
9. AGE last birthday <u>1</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>- -</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Walter Harrison</u>				14. MOTHER'S MAIDEN NAME: <u>Evelyn Harrison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
587.2 IMMEDIATE CAUSE (A) <u>acute + chronic pneumonia</u>			
ANTECEDENT CAUSE (S) (B) <u>chronic bronchitis + bronchectasis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>2 bronchopneumonia of pancreas</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			

19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec 22, 1955 to Jan 20, 1956, that I last saw the deceased alive on Jan 20, 1956, and that death occurred at M, from the causes and on the date stated above.

SIGNATURE <u>Gordon Trukin, M.D.</u>		ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>1/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal + Burial</u>		DATE THEREOF <u>Jan 21, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Herndon, Virginia</u>		24. FUNERAL DIRECTOR <u>Red-Green Funeral Home</u>		ADDRESS <u>Herndon, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/23/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 25 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00761

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8818 Hawkins Lane.,</u>				STREET ADDRESS (If rural give location) <u>8818 Hawkins Lane.,</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Emily</u> (Middle) (Last) <u>Hawkins</u>				(Month) (Day) (Year) <u>Jan. 21, 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>July 22, 1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Bradley Carroll</u>				14. MOTHER'S MAIDEN NAME <u>Hariett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Ella C. Hawkins 8818 Hawkins Lane., Chevy Chase, Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebro-vascular-accident</u>						<u>1 wk</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>corebral arteriosclerosis</u>						<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Broncho pneumonia</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-4</u> , 19 <u>56</u> , to <u>1-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-21</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> p.m. from the causes and on the date stated above.							
SIGNATURE <u>Dr. S. S. Sill</u>				ADDRESS (Street, city, town, state) <u>M.D. 7511 Arlington Rd. Bethesda 14, Md</u>		DATE SIGNED <u>1/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/24/56</u>	NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		LOCATION (City, town, or county) <u>Suitland, Md.</u>		(State)	
24. REC'D BY REGISTRAR <u>1-26-56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sinner - Rockville</u>		ADDRESS <u>Rockville</u>			

BUREAU V.

AN 30 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

798

CERTIFICATE OF DEATH

00762

214

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>MARYLAND</u>		STATE <u>D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN				TOWN <u>Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14511 Colesville Rd.</u>				STREET ADDRESS (If rural give location) <u>719 8th St. N.E.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ROBERT</u>		(Middle)		(Last) <u>HAYES</u>		(Month) (Day) (Year)	
SEX <u>M</u>		COLOR OR RACE <u>White</u>		SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		DATE OF BIRTH <u>July 17, 1876</u>	
AGE last birthday <u>79</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MONTHS		DAYS		HOURS		MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. D.C. Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fireman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Hayes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>Spanish-American</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Lillie Stack</u>	
						<u>719 8th St. N.E. D.C.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 Min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March</u> , 19 <u>54</u> , to <u>Dec 26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 26</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>1-4-56</u>			
ADDRESS (Street, city, town, state) <u>M.D. 2902 Porter St. N.W. D.C.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-6-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>308 4th St. N.E.</u>	
DATE <u>1-10-56</u>							

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery County MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural TOWN Bethesda Rural HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE So. Carolina COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Beaufort STREET ADDRESS (If rural give location) P.O. Box 129	
3. NAME OF DECEASED: (Type or Print) James Paul HENDRICKS		4. DATE (Month) (Day) (Year) OF DEATH: January 14 19 56	
5. SEX: Male	6. COLOR OR RACE: Cauc	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: June, 1, 1915
9. AGE last birthday 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: James Robert HENDRICKS		14. MOTHER'S MAIDEN NAME: Mary Jane	
15. WAS DECEASED EVER IN U.S. ARMY, NAVY, MARINE CORPS, AIR FORCE, COAST GUARD, OR RESERVE? (Yes, no, or unk.) (If Yes, give war or dates) Yes U.S.M.C. Since 1-2-36		16. SOCIAL SECURITY NO. none	
17. INFORMANT & ADDRESS: Beaufort, S.C. Wife: Marie HENDRICKS, P.O. Box 129,			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 193X IMMEDIATE CAUSE (A) Medullary Compression ANTECEDENT CAUSE (S) DUE TO Glioblastoma Multiforme DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Lobular Pneumonia (C)			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 14 Jan., 1956 , to 14 Jan., 1956 , that I last saw the deceased alive on 14 Jan., 1956 , and that death occurred at 5:10 P.M. from the causes and on the date stated above. SIGNATURE Gerald I. Shugoll ADDRESS DATE SIGNED Gerald I. Shugoll LTJG, MC, USN U. s. Naval Hospital, NMMC, Bethesda, Maryland			
23. BURIAL, CREMATION, (SPECIFY) BURIAL		DATE THEREOF 18 Jan 1956	
NAME OF CEMETERY OR CREMATORY EVERGREEN CEMETERY		LOCATION (City, town, or county) (State) Beaufort, South Carolina	
DATE REC'D BY LOCAL REGISTRAR 16 Jan 1956		REGISTRAR'S SIGNATURE Mary C. Cassell	
24. FUNERAL DIRECTOR R.A. PUMPHREY		ADDRESS 7557 Wisconsin Ave. Bethesda, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 24 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **00764**No. **216**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) Bethesda			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.#3				STREET ADDRESS R.F.D.#3		(If rural, give location)	
3. NAME OF DECEASED: (First) Danny		(Middle) Lee		(Last) HILL		4. DATE OF DEATH (Month) January (Day) 5 (Year) 19 56	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 6-1-1955	9. AGE last birthday: yrs. 7 Months 7 Days 4 Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): infant		10b. KIND OF BUSINESS OR INDUSTRY: none		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Chester A. Hill				14. MOTHER'S MAIDEN NAME: Nancy Doan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No.: --		17. INFORMANT & ADDRESS: Father Chester A. Hill - above add.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
493X Immediate cause (a) Pneumonia DUE TO						24 hours	
Antecedent cause(s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.		DATE SIGNED Jan. 5, 1956			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 1-7-1956		NAME OF CEMETERY OR CREMATORY Parklawn		LOCATION (City, town, or county) (State) Rockville Md	
DATE REC'D BY LOCAL REG. 1/9/56		REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>		24. FUNERAL DIRECTOR <i>Robert A. Humphrey</i>		ADDRESS Bethesda, Md	

2074222404

RECEIVED

JAN 11 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 216.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Derwood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Robert R. Hogston</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>JAN 15 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 5</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Plumbers helper</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Smith Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME: <u>Samuel Hogston</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Surber</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Wife - Ethel Hogston</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>cerebral anoxia</u>						<u>15 min</u>	
ANTECEDENT CAUSE (B) <u>cerebral thrombosis</u>						<u>36 hr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension</u>						<u>2 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/12/56</u> , 19 <u>56</u> , to <u>1/15/56</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>1/15/56</u> , 19 <u>56</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Hogston</u>		M. D. <u>Robert R. Hogston</u>		DATE SIGNED <u>1/15/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>1-18-56</u>		NAME OF CEMETERY OR CREMATORY <u>Elizabeth Cemetery</u>		LOCATION (City, town, or county) (State) <u>Smith County, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/20/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Thompson</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 21 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Takoma Park</i>	<i>D.O.A.</i>	TOWN <i>Silver Spring</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<i>Washington Sanitarium and Hospital</i>		<i>600 Thayer Ave</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Wionel Landon Hood</i>		DEATH: <i>Jan 16 1956</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
<i>M</i>	<i>Cauc.</i>	<i>married</i>	<i>Dec 28, 1906</i>
9. AGE last birthday		IF UNDER 1 YEAR	
<i>49</i> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<i>Signal Corp U.S. Army civilian employee.</i>		<i>Temple Texas</i>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Amer.</i>		<i>Amer.</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Eugene Hood</i>		<i>Callie De Bord</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.:	
<i>no</i>		<i>455-07-7030</i>	
17. INFORMANT & ADDRESS:			
<i>Mrs. Earon Hood - wife - Sameas deceased.</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE			
(A) <i>Acute Heart Failure</i>			<i>1 hour</i>
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(B) <i>Acute Coronary Occlusion (Second Episode)</i>			<i>1 hour</i>
(C) <i>Arteriosclerotic Heart Disease</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<i>0</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Nov 5</i> , 1955, to <i>Jan 16</i> , 1956, that I last saw the deceased alive on <i>1/13</i> , 1956, and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<i>Benjamin Dawson</i>		<i>1/16/56</i>	
M. D. <i>7733 Aloha Ave. N.W. Wash. D.C.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<i>Trans. & Burial</i>		<i>1/20/56</i>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Hillcrest Cemetery</i>		<i>Temple, Bell County, Texas</i>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<i>Jan 17-1956</i>		<i>Warner E. Humphrey</i>	
REGISTRAR'S SIGNATURE		ADDRESS	
<i>John Deak</i>		<i>8434 Ga. Ave. Silver Spring, Maryland</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 19 1956

RECEIVED

Signal Corps.
5,6700

CERTIFICATE OF DEATH

Reg. Dist. No. 214

82

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring
 TOWN Silver Spring LENGTH OF STAY (in this place) since 1938
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 839 Gist Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring
 TOWN Silver Spring (If rural, give location)
 STREET ADDRESS 839 Gist Ave.

3. NAME OF DECEASED: (First) (Middle) (Last)

DECEASED: John
 (Type or Print) Joseph
Hurley

4. DATE OF DEATH: (Month) (Day) (Year)

DATE OF DEATH: Jan 17 19 56
 9. AGE last birthday: 65 yrs.

5. SEX: 6. COLOR OR RACE:

5. SEX: Male
 6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH:

8. DATE OF BIRTH: May 15, 1890

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

9. AGE last birthday: 65 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper - U. S. Patent Office

10b. KIND OF BUSINESS OR INDUSTRY: (Gov't.)

10b. KIND OF BUSINESS OR INDUSTRY: (Gov't.) Unionville, Conn.

11. BIRTHPLACE (State or foreign country):

11. BIRTHPLACE (State or foreign country): U.S.A.

12. CITIZEN OF WHAT COUNTRY?

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

13. FATHER'S NAME: John Hurley

14. MOTHER'S MAIDEN NAME:

14. MOTHER'S MAIDEN NAME: Maria Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) yes WW #1

16. SOCIAL SECURITY No.:

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS:

17. INFORMANT & ADDRESS: Mrs. Jane Molumphy, 114 N. Main St. West Hartford, Conn.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

260x
 Immediate cause

(a) DUE TO

Acute Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

Sudden Death

Antecedent cause(s)

(b) DUE TO

Atherosclerosis

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c) DUE TO

Diabetes Mellitus

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

19a. DATE OF OPERATION: Jan 17, 1956 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

21. ACCIDENT SUICIDE HOMICIDE (Specify) Accident

PLACE (Home, farm, factory, street, OF office bldg., etc.)

PLACE (Home, farm, factory, street, OF office bldg., etc.) Home

(CITY OR TOWN)

(CITY OR TOWN) Unionville, Conn.

(COUNTY)

(COUNTY) Unionville, Conn.

(STATE)

(STATE) Conn.

TIME (Month) (Day) (Year) (Hour) OF INJURY Jan 17, 1956 12:15 P.M.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

HOW DID INJURY OCCUR? Heart attack

22. I hereby certify that I attended the deceased from Nov 17, 1955, to Jan 16, 1956, that I last saw the deceased alive on Jan 16, 1956, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

SIGNATURE

SIGNATURE Philip C. Jones M.D.

(DEGREE OR TITLE) ADDRESS

(DEGREE OR TITLE) ADDRESS 918 Ellsworth Dr Silver Spring Md

DATE SIGNED

DATE SIGNED Jan 17, 1956

23. BURIAL, CREMATION REMOVAL (Specify):

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF

DATE THEREOF 1/19/56

NAME OF CEMETERY OR CREMATORY

NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery

LOCATION (City, town, or county) (State)

LOCATION (City, town, or county) (State) Arlington, Virginia

DATE REC'D BY LOCAL REG.

DATE REC'D BY LOCAL REG. 1-20-56

REGISTRAR'S SIGNATURE

REGISTRAR'S SIGNATURE Francis Potter

24. FUNERAL DIRECTOR

24. FUNERAL DIRECTOR Walter E. Pumphrey

ADDRESS

ADDRESS Silver Spring, Md.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00768

Reg. Dist. No. 219

Items 1,12 FilmG191 1-13-56 et

1. PLACE OF DEATH- COUNTY <i>Montg</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>md</i>		COUNTY <i>Montg</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Germantown</i>		LENGTH OF STAY (in this place) <i>1 yr</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Germantown</i>		STREET ADDRESS (If rural, give location) <i>Germantown</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Maryland Rest Home</i>		3. NAME OF DECEASED (First) (Middle) (Last) <i>Laura Hussar</i>		4. DATE OF DEATH Month <i>1</i> - Day <i>7</i> - Year <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>May 21 1878</i>	9. AGE last birthday <i>77</i> yrs.	If under 1 year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>W</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thos Kluge</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Madu</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <i>Rest Home Records</i>							

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.1</i> Immediate cause (a) <i>Coronary occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>3 years</i>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <i>Coronary sclerosis</i>		
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan 6*, 19*56*, to *Jan 7*, 19*56*, that I last saw the deceased alive on *Jan 6*, 19*56*, and that death occurred at *4:20 P*. m., from the causes and on the date stated above.

SIGNATURE <i>Vernon E. Spillers M.D.</i>	(Degree or title)	ADDRESS <i>Germantown md</i>	DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify) <i>11/15/56</i>	DATE THEREOF	NAME OF CEMETERY OR CREMATORY <i>Washington, D.C.</i>	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <i>1-9-56</i>	REGISTRAR'S SIGNATURE <i>Laurel H. Hughes</i>	24. FUNERAL DIRECTOR <i>W.R. H. ...</i>	ADDRESS

5732 Ma. Ave. N.W.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

De Maurice

BUREAU V. S.

JAN 11 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <i>Montgomery</i>	MARYLAND		STATE <i>Maryland</i>	COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	56	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburban Hospital</i>			STREET ADDRESS (If rural give location) <i>12117 Georgia Avenue</i>	1	
3. NAME OF DECEASED: (Type or Print) <i>Garnett DeWitt Incoe, Sr</i>			4. DATE (Month) (Day) (Year) OF DEATH: <i>1-15-1956</i>		
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>8-21-92</i>	9. AGE last birthday <i>63</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Grocery Clerk</i>			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME: <i>Uriah Incoe</i>			14. MOTHER'S MAIDEN NAME: <i>Chrismond, Annette</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>yes</i>			16. SOCIAL SECURITY NO. <i>577-03-1141</i>	17. INFORMANT & ADDRESS: <i>Garnett D. Incoe, Jr.</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
141X IMMEDIATE CAUSE	(A) <i>Bronchopneumonia, bilateral</i>	<i>week?</i>
ANTECEDENT CAUSE (S)	(B) <i>metastatic carcinoma liver</i>	<i>8 mos.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C) <i>carcinoma tongue</i>	<i>3 1/2 yrs.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Adenoma tumor, bilateral</i>		

19A. DATE OF OPERATION: <i>Nov. 1952</i>	19B. MAJOR FINDINGS OF OPERATION: <i>Rounded pink nodules, tongue</i>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Dec 26*, 1955, to *Jan 15*, 1956, that I last saw the deceased alive on *Jan 15*, 1956, and that death occurred at *9:15 P* M, from the causes and on the date stated above.

SIGNATURE <i>John Lawrence Avery MD.</i>	M. D.	DATE SIGNED <i>Jan 15/56</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>Jan 19, 1956</i>	NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>
LOCATION (City, town, or county) <i>Prince George Co Md</i>		
DATE REC'D BY LOCAL REGISTRAR <i>1/18/56</i>	REGISTRAR'S SIGNATURE <i>Beattie M. Thompson</i>	24. FUNERAL DIRECTOR ADDRESS <i>J. Arthur Walters, 254 Carroll St NW Wk</i>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 20 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda
 OR TOWN Bethesda
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Alta Vista Rest Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda
 OR TOWN Bethesda
 STREET ADDRESS (If rural give location) 7802 Maple Ridge Rd.

3. NAME OF DECEASED:

(First) Julia (Middle) Jane (Last) JENNER

4. DATE (Month) (Day) (Year) OF DEATH: Jan 28 19565. SEX: F6. COLOR OR RACE: Wh7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify): widowed8. DATE OF BIRTH: Oct. 17, 18769. AGE last birthday: 79 yrs. 3 Months 11 Days Hours Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Doctor, Gen. Practice10B. KIND OF BUSINESS OR INDUSTRY: Doctor11. BIRTHPLACE (State or foreign country): Gallatin Missouri12. CITIZEN OF WHAT COUNTRY? U.S.13. FATHER'S NAME: Joshua Willis Alexander14. MOTHER'S MAIDEN NAME: Roe ANN Richardson15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no15. SOCIAL SECURITY NO. None17. INFORMANT & ADDRESS: Mr. Preston A. Alexander Bethesda, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491X

IMMEDIATE CAUSE

(A) DUE TO Broncho pneumonia

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.

(B) DUE TO 5 yrs. bed invalidism from(C) senility + fractured vertebraINTERVAL BETWEEN ONSET AND DEATH 72 hrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1940 to 1-28, 1956, that I last saw the deceased alive on 1-27, 1956, and that death occurred at 9:20 P.M., from the causes and on the date stated above.

SIGNATURE Wm. M. Ballinger

M. D.

ADDRESS 1801 Eye N.W. DATE SIGNED 1-29-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

BurialDATE THEREOF 2-1-1956NAME OF CEMETERY OR CREMATORY Ft. Lincoln CemLOCATION (City, town, or county) Prince GeorgesMdDATE REC'D BY LOCAL REGISTRAR 1-31-56REGISTRAR'S SIGNATURE Beanie M. Thompson24. FUNERAL DIRECTOR Robert A. HumphreyADDRESS Bethesda, Md.

MARGIN RESERVED FOR BINDING

RECEIVED

FEB 3 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00771

Reg. Dist.

No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Gaithersburg</i>		LENGTH OF STAY (in this place) <i>11 yrs</i>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Gaithersburg</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>RFD # 3</i>				STREET ADDRESS (If rural, give location) <i>1270 #3</i>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <i>Ella Mae</i>		(Middle) <i>Johnson</i>		(Last)		(Month) (Day) (Year) <i>Jan 23 1956</i>	
5. SEX: <i>F</i>		6. COLOR OR RACE: <i>Col</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>Oct 5 1911</i>	
9. AGE last birthday: <i>44</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work, life, even if retired): <i>Housewife</i>		11. BIRTHPLACE (State or foreign country): <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Oscar Randolph</i>				14. MOTHER'S MAIDEN NAME: <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Virginia Mc Donald - Rockville md</i>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <i>Hemiparesis</i>				<i>20-30 min</i>	
Antecedent cause(s)		(b) <i>Numerous purpuring wounds of ants</i>				<i>20-30'</i>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) <i>Shot-gun pellets</i>				<i>20-30'</i>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <i>Home</i>		21c. (City or town) (County) (State) <i>Gaithersburg RFD. Montg md</i>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>7:30 PM - 1-23-56 M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Shot by husband</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE: <i>Frank J. Broschaut</i>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED: <i>1-24-56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>1-27-56</i>		NAME OF CEMETERY OR CREMATORY: <i>Rocky Hill</i>		LOCATION (City, town, or county) (State): <i>Clarkburg, md</i>	
DATE REC'D BY LOCAL REG. <i>1/25/56</i>		REGISTRAR'S SIGNATURE: <i>Laurel H. Bryant</i>		FUNERAL DIRECTOR: <i>Robert L. Snowden - Rockville, md</i>		ADDRESS:	

RECEIVED

JAN 26 1956

BUREAU V. S.

807

00772

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 217

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Montg</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Rockville (rural)</u>	<u>1 hr</u>	TOWN <u>Rockville (rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Smith Store, Norbeck</u>		STREET ADDRESS (If rural, give location) <u>1270</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Elbert</u>	(Middle)	(Last) <u>Johnson</u>	(Month) <u>Jan</u> (Day) <u>27</u> (Year) <u>1956</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>	8. DATE OF BIRTH: <u>Mar. 10, 1907</u>
9. AGE last birthday: <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY:	
13. FATHER'S NAME: <u>John Johnson</u>		14. MOTHER'S MAIDEN NAME: <u>Emma Pratt</u>	
15. W. DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>W.W. #2</u>		16. SOCIAL SECURITY No.: <u>Ella Johnson - Newwood, MD</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Coronary occlusion</u>	DUE TO	<u>Sudden death</u>
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>	DUE TO	
(c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Frank J. Byerschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-27-56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>2-1-56</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>
LOCATION (City, town, or county) (State) <u>Arlington Va</u>	DATE REC'D BY LOCAL REG. <u>1-31-56</u>	REGISTRAR'S SIGNATURE <u>Gertrude Barber</u>
24. FUNERAL DIRECTOR <u>Robert L. Suonke - Rockville MD</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 3 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00773

808

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	STATE <i>Washington</i> COUNTY <i>D.C.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>47K-3</i>
OR TOWN <i>Silver Spring</i>	LENGTH OF STAY (in this place) <i>3 1/2 months</i>	OR TOWN	STREET ADDRESS (If rural give location) <i>6713 14th St. N.W.</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>12819 Connecticut Ave.</i>			
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Mary</i> (Middle) (Last) <i>Johnson</i>	(Type or Print)	(Month) <i>Jan</i> (Day) <i>22</i> (Year) <i>1956</i>	
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH: <i>12/7/69</i>
		9. AGE last birthday: <i>86</i> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if only part time <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Sweden</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME: <i>Andrew Olson</i>		14. MOTHER'S MARDEN NAME: <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>daughter 12819 Conn. Ave. Elsie Stackel</i>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.		Interval Between Onset And Death	
Immediate cause (a) <i>331X Cerebral vascular accident</i>		<i>24 hours</i>	
Antecedent causes (s) (b) <i>Generalized arteriosclerosis</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <i>Congestive heart failure.</i>			
19a. DATE OF OPERATION: <i>10/29/55</i>		19b. MAJOR FINDINGS OF OPERATION: <i>Deep femoral thrombosis left leg with gangrene</i>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <i>None</i>		20. AUTOPSY? <i>No</i>	
PLACE (Home, farm, factory, street, or office bldg.) <i>None</i>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>None</i>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR? <i>None</i>	
22. I hereby certify that I attended the deceased from <i>10/23, 1956</i> , to <i>1/22, 1956</i> that I last saw the deceased alive on <i>1/20, 1956</i> and that death occurred at <i>9:30 AM</i> from the causes and on the date stated above.			
SIGNATURE <i>John B. Unkham</i>		ADDRESS <i>8805 Conn. Ave.</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Transit & Burial</i>		DATE THEREOF <i>1-25-1956</i>	
NAME OF CEMETERY OR CREMATORY <i>Brooklyn New York</i>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <i>1-22-1956</i>		REGISTRAR'S SIGNATURE <i>Frances Potter</i>	
		24. FUNERAL DIRECTOR <i>S.N. Harris Co.</i>	
		ADDRESS <i>2901 14th St. N.W. D.C.</i>	

BUREAU V. S.

JAN 25 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01193

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Silver Spring (Montgomery)</u> MARYLAND CITY <u>Silver Spring</u> (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Silver Spring (Montgomery)</u> CITY <u>Silver Spring</u> (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u> STREET ADDRESS <u>1923-EAST WEST HIGHWAY, S.S. MD.</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Lucie B. Jones</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>Jan 2</u> 19 <u>56</u> (Month) (Day) (Year)			
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>APRIL 6, 1874</u>	9. AGE last birthday <u>81</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>STORE</u>				11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>SAMUEL JONES</u>				14. MOTHER'S MAIDEN NAME <u>JULIANNA THOMPSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-05-9979A</u>		17. INFORMANT & ADDRESS <u>FRANK P. KULP, 1923-EAST WEST HWY. (NEPHEW)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart Failure</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Heart Disease</u>						<u>Unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from <u>Jan 2</u> , 19 <u>56</u> to <u>Jan 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>56</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James M. Loftis</u>		M.D. <u>1673-Bark Road - Wash D.C.</u>		DATE SIGNED <u>Jan 2 56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Anne's</u>		LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
24. REC'D BY REGISTRAR <u>Jan. 3, 1956</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James M. Loftis</u> ADDRESS <u>Annapolis, Md.</u>			

BUREAU V. S.

JAN 6 1956

RECEIVED

[illegible]

810

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>16 days</u>		CITY (If outside corporate limits, write and give nearest town) <u>5209 Acacia Ave.</u>		TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>				STREET ADDRESS (If rural give location) <u>Bethesda</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Robert Almon</u> <u>JULIA (JR)</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>19</u> <u>1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 12, 1886</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Broker</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Robert Almon Julia Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Ella Urania Baker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>UNKNOWN</u>		17. INFORMANT & ADDRESS: <u>Wife - Virginia S. Julia - above</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
42211	(A) <u>Acute Pulmonary Edema</u>	
IMMEDIATE CAUSE	DUE TO	
ANTECEDENT CAUSE (S)	(B) <u>Rt. Cardiovascular Incident with right homoplegia</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO	
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Benign Prostatic Hypertrophy</u>		

19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/3, 1956, to 1/19, 1956, that I last saw the deceased alive on 1/18, 1956, and that death occurred at 9:54 M, from the causes and on the date stated above.

SIGNATURE <u>J. L. Markham, M.D.</u>	ADDRESS <u>M.D. 6306 Wisconsin Ave</u>	DATE SIGNED <u>1/19/56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>	DATE THEREOF <u>1/20/1956</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>
		LOCATION (City, town, or county) (State) <u>Prince George Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>1/20/56</u>	REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>
		ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

RECEIVED

JAN 24 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY
 OR and give nearest town) 17 TOWN Takoma Park (in this place)
 HOSPITAL OR 90 Eventide Rest Home
 STREET ADDRESS 700 Hudson Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR Silver Spring
 TOWN 56
 STREET (If rural give location)
 ADDRESS 9409 New-Hampshire Rd

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HectorBKeener

4. DATE

(Month)

(Day)

(Year)

OF DEATH:

1321956

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

MWWidowedSept-16-187877 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

FARMERINDUSTRY:Va.USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Walter KeenerMary Pangle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

noRobert L. Keener (Son)1628 Futaba St
Baltimore, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

177X
Immediate causeBroncho-pneumonia bilateral

Interval Between Onset And Death

4 daysAntecedent causes (s)
Diseases or conditions, if any,
giving rise to the above cause,
stating the underlying cause last.DUE TO Primary Carcinoma of Prostatemultiple metastases to abdominal viscera and lymph nodes1 1/2 yearsArterial embolism, left femoral artery2 months

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Arteriosclerosis, generalizedUndetermined

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

Dec 4, 1954Carcinoma of Prostate, multiple metastases

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 2, 1954, to Jan 22, 1956, that I last saw the deceasedalive on Jan 21, 1956, and that death occurred at 11:00 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 22-1956
J. Wilson Dodd514 Hines Co, 2901 14th St NW
WASH. D.C.

BUREAU V. S.

JAN 26 1956

RECEIVED

811
CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>Bethesda</u>	<u>26 hours</u>	<u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Suburban Hosp.</u>		<u>9721 Montauk Ave.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print) (First) (Middle) (Last)		OF DEATH: <u>Jan 3 1956</u>	
<u>Anna Baptista Kelly</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>		<u>Feb. 10, 1875</u>
9. AGE last birthday		IF UNDER 1 YEAR	
<u>80</u> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Housewife</u>			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Iowa</u>		<u>U.S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>James Stanton</u>		<u>Mary Galligan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>None</u>	
17. INFORMANT'S ADDRESS:		Item # 2	
<u>Mrs. R.E. Cavanaugh-daughter</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4341 IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>		<u>26 days</u>	
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Congestive Heart Failure</u> <u>4 years</u>	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 17</u> , 19 <u>55</u> , to <u>Jan 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 3</u> , 19 <u>56</u> , and that death occurred at <u>1:00</u> P.M., from the causes and on the date stated above.			
SIGNATURE <u>J. R. Reed M.P.</u>		M. D. 3701 Leland St. Ch. Ch. Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial-Transit</u>		<u>1-4-56</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>St. Josephs</u>		<u>Chickasaw Co., Iowa</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>1/4/56</u>		<u>Bessie M. Shorrock</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Robert M. Humphrey</u>		<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATE OF MARYLAND

19

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BUREAU V. S.

JAN 9 1896

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

812

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Virginia	COUNTY Alexandria
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural	LENGTH OF STAY (in this place) 1 Mo 15da	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural give location) 3203 Old Dominion Blvd.	

3. NAME OF DECEASED:	(First) William	(Middle) Talty	(Last) KENNY	4. DATE (Month) (Day) (Year) OF DEATH:	Jan	20	56
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5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.
M	White	Married	2-17-05	50	Months 11	Days 11

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Mariner	U.S. NAVY	Tenn.	U.S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
John M. KENNY	Katherine TALTY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, Yes or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
Yes WWII Korea		W: Josephine C. KENNY

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) Thrombosis, Renal artery		2 days
ANTECEDENT CAUSE (S) (B) Thrombosis, Aorta, abdominal		+ 1 month
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Arteriosclerosis		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary edema Hypertension, arterial		8 hours - 6-7 years

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12-5-55**, to **1-20**, 19**56**, that I last saw the deceased alive on **1-20**, 19**56**, and that death occurred at **8A** M, from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
DR. CAROL A. MC	USN U. S. Naval Hospital, NNHC, Bethesda, Maryland	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
Burial	1-24-56	Arlington National
		LOCATION (City, town, or county) (State)
		Arlington Va.

DATE RECEIVED 1-20-56	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
	Joseph P. Cassella	R.A. PUMPHREY Funeral Home 7557 Wisconsin Avenue, Bethesda, Maryland

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 27 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

813

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00778

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Olney</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Gaithersburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County Gen. Hosp</u>				STREET ADDRESS (If rural give location) <u>Summit Hall Turf Farm</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Lona</u> <u>Miller</u> <u>Keplinger</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>27</u> <u>1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>80</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Louis F. Miller</u>				14. MOTHER'S MAIDEN NAME: <u>Frances Hilligoss</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
194X IMMEDIATE CAUSE (A) <u>Adenocarcinoma of Thyroid</u>						5 months	
ANTECEDENT CAUSE (S) DUE TO <u>Gland</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>Nov. 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of Thyroid</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 3</u> , 1956, to <u>Jan. 27</u> , 1956, that I last saw the deceased alive on <u>Jan. 27</u> , 1956, and that death occurred at <u>5</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Jack Schumacher</u>		ADDRESS <u>Baltimore, Md.</u>		DATE SIGNED <u>Jan. 27, '56</u>		M.D. <u>Baltimore, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 20, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Rockville Union Cem</u>		LOCATION (City, town, or county) (State) <u>Rockville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-28-56</u>		REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>		24. FUNERAL DIRECTOR <u>S. C. Pumpfroy</u>		ADDRESS <u>7557 W. Ave. Beth. Md.</u>	

RECEIVED
FEB 1 1956
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00779

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		STATE <u>Md.</u> COUNTY <u>Mont.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>1 day</u>		STREET ADDRESS (If rural give location) <u>Rt. 1, Bel Pre Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Barbara Emeline King</u>				OF DEATH: <u>Jan 4, 1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>Dec. 5, 1929</u>	9. AGE last birthday <u>26</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Raymond Milton Clark</u>				14. MOTHER'S MAIDEN NAME: <u>Marguerite Turner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>4-1-1-1-1-1-1-1-1-1</u>		17. INFORMANT & ADDRESS: <u>Herman King - husband</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>154X</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Adenocarcinoma, Metastatic,</u>						<u>1 yr</u>	
DUE TO <u>Liver, Lungs.</u>							
(B) <u>Adenocarcinoma, Rectum</u>						<u>1 yr</u>	
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Portal obstruction due to Hepatomegaly -</u>							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 15, 1955</u> , to <u>Jan. 3, 1956</u> , that I last saw the deceased alive on <u>Jan. 3, 1956</u> , and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Albert S. Norton</u>		M. D. <u>Bethesda Md</u>		DATE SIGNED <u>1/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 7, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Coleville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Coleville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/4/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Therese E. Humphrey</u>		ADDRESS <u>8/30/ Georgia Ave. Silver Spring Md.</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 9 1955

RECEIVED

815

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Brookmont</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Brookmont</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD Bethesda</u>		STREET ADDRESS (If rural give location) <u>RFD Bethesda</u>	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>James</u>	(Middle) <u>Herbert</u>	(Last) <u>KING</u>	DEATH: <u>January 3</u> <u>1956</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Jan. 11-1880</u>
		9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR: Months <u>11</u> Days <u>22</u> Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Canal Lockkeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>C & O RR</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			

13. FATHER'S NAME: <u>Benj. F. King</u>		14. MOTHER'S MAIDEN NAME: <u>Harriet Frances Sullivan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u> <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Julia King, sister-in-law -6100 Ridge Dr. Wash 16, D.C.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>		<u>Sudden</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Heart Disease</u>		<u>3 YEARS</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) <u>Bronchopneumonia</u>		<u>7 DAYS</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. <u></u>	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 6, 1950, to Jan 3, 1956, that I last saw the deceased alive on Dec 29, 1955, and that death occurred at 0201 M, from the causes and on the date stated above.

SIGNATURE Paul S. Anglin ADDRESS M. D. 5009 DelRay Ave. Beth. Md. DATE SIGNED 1-4-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>11-6-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Walkers Chapel</u>	LOCATION (City, town, or county) (State) <u>Arlington Va.</u>
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DATE REC'D BY LOCAL REGISTRAR <u>1/4/56</u>	REGISTRAR'S SIGNATURE <u>Benjamin M. Thompson</u>	24. FUNERAL DIRECTOR <u>W. A. Pumphrey</u>	ADDRESS <u>Bethesda, Md.</u>
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MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 9 1956

BUREAU V. S.

816

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Mont.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. Rockville</u>	LENGTH OF STAY (in this place) <u>3 mos.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. Rockville</u>	(If rural, give nearest town) <u>Silver Spring</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>12818 Parkland Dr.</u>		STREET ADDRESS <u>12818 Parkland Dr.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Marilyn</u>	(Middle) <u>Jeanette</u>	(Last) <u>Klee</u>	(Date) <u>1</u> (Month) <u>1</u> (Day) <u>19</u> (Year) <u>56</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>9-28-55</u>
9. AGE last birthday: <u>3</u> yrs. <u>4</u> Months <u>4</u> Days		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>none</u>	
11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William Walter Klee</u>		14. MOTHER'S MAIDEN NAME: <u>Winifred Quinn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>none</u>	
17. INFORMANT & ADDRESS: <u>W. W. Klee, 12818 Parkland Dr., Rockville, Md.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>22 hrs.</u>
<u>493X</u> Immediate cause (a) <u>Pneumonia</u> DUE TO Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) _____ DUE TO (c) _____		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Mongolian Idiocy</u>		
19a. DATE OF OPERATION: <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>12-31</u> , 19 <u>55</u> , to <u>1-1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-31</u> , 19 <u>55</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.		
SIGNATURE <u>D. A. St. Martin</u> (Degree or title) <u>MD</u>		DATE SIGNED
ADDRESS <u>9820 Dameron Dr., Silver Spring, Md.</u>		
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>1/3/56</u>	<u>St. John's Cemetery</u>
LOCATION (City, town, or county) (State)	<u>Silver Spring, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>Jan 3/56</u>	<u>Frances Potter Warner</u>	<u>E. Humphrey</u>
ADDRESS <u>8434 Ga. Ave.</u>		<u>Silver Spring, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00782

817

CERTIFICATE OF DEATH

Item 14, Film 91 1-23-56 et

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>MONTGOMERY</u> MARYLAND		STATE <u>md</u> COUNTY <u>Montg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
CITY OR TOWN <u>56 SILVER SPg</u>		LENGTH OF STAY (in this place)		STREET ADDRESS <u>17 Hilltop Rd</u>		STREET ADDRESS (If rural give location) <u>17 Hilltop Rd</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17 Hilltop Rd</u>							
3. NAME OF DECEASED (Type or Print) <u>DEBORAH LOUIS KNOBLOCK</u>				4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>16</u> (Year) <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>child</u>		8. DATE OF BIRTH <u>DEC 20 1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>26</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>PHILADELPHIA PA</u>	
13. FATHER'S NAME <u>SAUL KNOBLOCK</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA Polusky</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>SAUL KNOBLOCK 17 HILLTOP Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
7544 IMMEDIATE CAUSE (A) <u>Congenital Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 12, 1956</u> to <u>Jan 16, 1956</u> that I last saw the deceased alive on <u>Jan 16, 1956</u> and that death occurred at <u>3:45</u> M. from the causes and on the date stated above. SIGNATURE <u>Joseph Rose</u> DATE SIGNED <u>1-16-56</u> ADDRESS (Street, city, town, state) <u>M.D. 4829-16 St. N.W., Wash D.C.</u>							
23. BURIAL, CREMATION, REMOVAL, ETC.		DATE THEREOF <u>1-16-56</u>		NAME OF CEMETERY OR CREMATORY <u>George Wash Maus Quater</u>		LOCATION (City, town, or county) (State) <u>Depaulville Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Francis Potter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>		ADDRESS <u>Wash D.C.</u>	
DATE <u>1-19-56</u>							

RECEIVED

JAN 20 1956

BUREAU V. S.

CERTIFICATE OF DEATH

STATE OF MISSOURI DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

0075

721

CERTIFICATE OF DEATH

Reg. Dist. No. 423

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>a.a.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u>	LENGTH OF STAY (in this place) <u>5 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Burnie</u>	<u>02X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San and Hospital</u>		STREET ADDRESS (If rural give location) <u>101 M St. S.E.</u>	✓

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Mary</u>	(Middle) <u>Newton</u>	(Last) <u>Kreider</u>	DATE OF DEATH: <u>January 16 1956</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 17, 1884</u>
		9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>	11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME: <u>Unknown - Ballman</u>	14. MOTHER'S MAIDEN NAME: <u>Unknown</u>
--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT & ADDRESS: <u>Chart - Mr Charles Kreider (same)</u>
---	--	--

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>		<u>13 hrs</u>
ANTECEDENT CAUSE (B) <u>Essential hypertension</u>		<u>Many yrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 11, 1956, to Jan 16, 1956, that I last saw the deceased alive on Jan 15, 1956, and that death occurred at 7:05 A.M., from the causes and on the date stated above.

SIGNATURE <u>Raymond O. West</u>	ADDRESS <u>M. D. Takomas Jk.</u>	DATE SIGNED <u>Jan 16/56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>January 18/56</u>	NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>
LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	24. FUNERAL DIRECTOR <u>W. H. Singleton</u>	ADDRESS <u>Glen Burnie, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>JAN-18-1956</u>	REGISTRAR'S SIGNATURE <u>L. J. Duddy</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 20 1956

BUREAU V. S.

Reg. Dist. No. 223...

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN Libertown, Md. x

STREET ADDRESS (If rural give location)
3806 Greenly St

4. DATE (Month) (Day) (Year)
OF
DEATH: JAN 24 1956

AGE last birthday 57 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
	Months	Days	Hours	Mins.

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): <i>England</i>	12. CITIZEN OF WHAT COUNTRY? <i>American</i>
--	---

14. MOTHER'S MAIDEN NAME:

18. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:
MRS. SALMA BRODSKY - same address

INTERVAL BETWEEN
ONSET AND DEATH

420.1

(A) Myocardial infarction
DUE TO

(C)

Planned expansion of Congressional Representation

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☒ NO ☐

21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR?	(City or town)	(County)	(State)

21E INJURY OCCURRED
While ☐ Not while ☐
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 7, 1956, to Jan 24, 1956, that I last saw the deceased alive on Jan 24, 1956, and that death occurred at 6:20 M, from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
<u>[Signature]</u>	<u>3600</u>	<u>Jan 24</u>

DATE THEREOF 1/1/1964

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 26 1956

RECEIVED

818

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
OR TOWN <u>Bethesda</u>		OR TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>1634 Brisbane St.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Clairne</u>	(Middle) <u>F.</u>	(Last) <u>LaVoie</u>	(Month) <u>Jan</u> (Day) <u>22</u> (Year) <u>1956</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>FEB. 24, 1899</u>
9. AGE last birthday <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Beautician</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>HAIRDRESSING</u>	
11. BIRTHPLACE (State or foreign country): <u>ST. HONORE, CHENLEY, CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>GUSTAVE PELLETIER</u>		14. MOTHER'S MAIDEN NAME: <u>MARIE BEAUDOIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>003-14-5141</u>	
17. INFORMANT & ADDRESS: <u>MRS. ALICE F. HEBERT, 1634 BRISBANE ST., SS., MD.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>			<u>5-6 hrs</u>
ANTECEDENT CAUSE (B) <u>Hypertension</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>52 to 22 Jan., 1956</u> that I last saw the deceased alive on <u>17 Jan., 1956</u> , and that death occurred at <u>2:55 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>William D. Aud</u>		DATE SIGNED <u>1/22/56</u>	
ADDRESS <u>906 Glenville Rd., S.E. 8th. 1/22/56</u>		M. D. <u>906 Glenville Rd., S.E. 8th. 1/22/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>SHIP. & BURIAL</u>		DATE THEREOF <u>JAN. 22, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>ST. PETER'S CEMETERY</u>		LOCATION (City, town, or county) (State) <u>LEWISTON, MAINE</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/23/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Wm. E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 25 1956

RECEIVED

Written permission rec'd from both parents
MARGIN RESERVED FOR BINDING

VS. A15 - 10-53
2075293292

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

723

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

00786

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Olney</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San & Hosp</u>		STREET ADDRESS (If rural give location) <u>Cashell Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
DECEASED: (Type or Print) <u>BABY GIRL LAYTON</u>		OF DEATH: <u>Jan. 30</u> 19 <u>56</u>	
5. SEX: <u>fe</u>	6. COLOR OR RACE: <u>cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Jan. 30, 1956</u>
9. AGE last birthday: <u>10</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Walter Adonis Layton</u>		14. MOTHER'S MAIDEN NAME: <u>Madge Evelyn Huntley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>PREMATURITY</u>			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 30, 1956</u> , to <u>Jan 30, 1956</u> that I last saw the deceased alive on <u>June 30</u> , 19 <u>56</u> , and that death occurred at <u>5:10 P M</u> , from the causes and on the date stated above.			
SIGNATURE <u>George R. Hance</u>		DATE SIGNED <u>9-2-70</u>	
ADDRESS <u>Washington D.C. S.S. 13156</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>2-6-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Washington San. & Hospital</u>		LOCATION (City, town, or county) (State) <u>Takoma Park 12, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 8-1956</u>		REGISTRAR'S SIGNATURE <u>J. Victor Dodd</u>	
24. FUNERAL DIRECTOR		ADDRESS	
R.A. Hare, M.D. Wash. San. & Hosp. Takoma			

RECEIVED
FEB 8 1956
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

749

00787

Reg. Dist.

No. 215

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Rockville</u>				TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1715 Crawford Drive</u>				STREET ADDRESS (If rural, give location) <u>1715 Crawford Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>LAWRENCE EVAN LEACOCK</u>				<u>Jan. 5, 19 56</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Single</u>		<u>Oct. 20, 1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Infant</u>		9. AGE last birthday: (If under 1 year) (Months) (Days) (Hours) (Min.) <u>2 yrs. 2 months 13 days</u>	
11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME: <u>John Leacock</u>				14. MOTHER'S MAIDEN NAME: <u>Alice Digley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>John Leacock-Item# 2</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>475X</u> Immediate cause (a) <u>ANOXIA</u> DUE TO Antecedent cause(s) (b) <u>OBSTRUCTION OF RESPIRATORY TRACT</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>Mucopurulent material from upper respiratory infection</u>				<u>30 MIN.</u> <u>50 MIN.</u> <u>2-6 hours</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>7-</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <u>John B. Ball.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/5/56</u> M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>	
LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>		DATE REC'D BY LOCAL REG. <u>1/6/56</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Grayson</u>	
DATE REC'D BY LOCAL REG. <u>1/6/56</u>		REGISTRAR'S SIGNATURE <u>Robert H. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. S.

JAN 9 1952

RECEIVED

819

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>60 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Nat'l Inst. of Health</u>				STREET ADDRESS (If rural give location) <u>1460 Eastern Ave. N. E.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mack</u> <u>--</u> <u>Lee</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>January 13, 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>January 18, 1895</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>District Govt.</u>		11. BIRTHPLACE (State or foreign country): <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Jap Lee</u>				14. MOTHER'S MAIDEN NAME: <u>Cellia Payne</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes</u> <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>THE medical record, The Clinical Center</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cancer of the Liver</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cor Pulmonale</u>							
19A. DATE OF OPERATION: <u>2</u>			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>			21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Nov 14, 1955</u> , to <u>Jan 13, 1956</u> , that I last saw the deceased alive on <u>Jan 13, 1956</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ted Clemens Jr.</u>				ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>1/14/56</u>	
M. D. <u>Nat'l Inst. of Health</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-18-56</u>		<u>Arlington Mt</u>		<u>Arlington Va</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-16-56</u>		REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>		24. FUNERAL DIRECTOR <u>John T. Stewart</u> ADDRESS <u>30 H St. N.E.</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 18 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

820

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00789

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>56 Silver Springs</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>700 Roeder Rd</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>George</u>	(Middle) <u>Leburn</u>	(Last) <u>Leese</u>	(Month) <u>Jan.</u> (Day) <u>5</u> (Year) <u>1956</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Jan 8-1884</u>
9. AGE last birthday: <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>26</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Potomac Power Co</u>	
11. BIRTHPLACE (State or foreign country): <u>Washington D C</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>H. Watson Leese</u>		14. MOTHER'S MAIDEN NAME: <u>Jennie C. Luckett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u></u>	
17. INFORMANT & ADDRESS: <u>M. Laura E. Leese</u>		<u>700 Roeder Rd Silver Springs</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
Immediate cause (a) <u>Coronary Thrombosis</u>			<u>12 hrs</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arteriosclerosis</u>			<u>10 yrs.</u>
(c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>Angina Pectoris</u>			
19a. DATE OF OPERATION: <u>None</u>			19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>March</u> , 19 <u>55</u> , to <u>4</u> <u>January</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-4</u> , 19 <u>56</u> , and that death occurred at <u>home</u> <u>1-5-56</u> from the causes and on the date stated above.			
SIGNATURE (Degree or title) <u>Francis I. Coleman M.D.</u>		ADDRESS <u>5315 16th St N.W.</u> DATE SIGNED <u>1-5-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Rural</u>		DATE THEREOF <u>Jan. 9-56</u>	NAME OF CEMETERY OR CREMATORY <u>Shenwood</u>
LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>1-6-56</u>		REGISTRAR'S SIGNATURE <u>Frances Tetterd</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>H. Hines Co 2901-14th St N.W.</u>	

BUREAU V. S.

JAN 10 1956

RECEIVED

821

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Bethesda Rural</u>		<u>12 days</u>		<u>Takoma Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>7122 Sycamore Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Susan Ann LEONARD</u>				<u>January 23 1956</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>Single</u>		<u>1-7-56</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		9. AGE last birthday IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Years Hours Min.	
						<u>16</u>	
11. BIRTHPLACE (State or foreign country): <u>Bethesda, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME: <u>Thomas E. LEONARD</u>				14. MOTHER'S MAIDEN NAME: <u>Helen UNSOELD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>-C-</u>		17. INFORMANT & ADDRESS: <u>Father Thomas E. LEONARD Same As above</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) DUE TO <u>Pneumonia, Aspiration</u>						<u>3 hrs.</u>	
ANTECEDENT CAUSE (B) DUE TO <u>Prematurity</u>						<u>16 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO <u>Malnutrition</u>						<u>11 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>23 Jan., 1956</u> , to <u>23 Jan., 1956</u> , that I last saw the deceased alive on <u>23 Jan</u> , 19 <u>56</u> and that death occurred at <u>12:55A</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. S. Matthews, M.D.</u>				ADDRESS <u>DATE SIGNED</u>			
<u>W. S. MATTHEWS LCDR, MC, USN U. S. Naval Hospital, NMMC, Bethesda, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>25 Jan 1956</u>		<u>Baltimore National Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>23 Jan 1956</u>		<u>Mary E. Carrelly</u>		<u>Fialkowski Funeral Home</u>		<u>2007 Eastern Ave, Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 27 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00791

822

CERTIFICATE OF DEATH

Reg. Dist. No. 216

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>MONTGOMERY</u>		STATE <u>MARYLAND</u>		STATE <u>47X-3</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
X TOWN <u>BETHESDA</u>				TOWN <u>WASHINGTON, DC.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5020 PARK PLACE</u>				STREET ADDRESS <u>6919-6th ST. NW</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>IDA</u> (Middle) (Last) <u>LERNER</u>				(Month) (Day) (Year) <u>JAN. 29-1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN-24-1885</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>SOLOMON J. GOLDBERG</u>				14. MOTHER'S MAIDEN NAME <u>ROSE -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>507-18-1911</u>		17. INFORMANT & ADDRESS <u>SAMUEL LERNER 5020 PARK PL. Bethesda, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
155X IMMEDIATE CAUSE (A) <u>Carcinoma of the gall-bladder</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>October 3, 1955</u>						19b. MAJOR FINDINGS OF OPERATION <u>Cancer of gall bladder - metastases to liver</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>December 19, 1955</u> , to <u>Jan. 29, 1956</u> , that I last saw the deceased alive on <u>Jan. 28, 1956</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Elaine W. Murphy</u> M.D.				ADDRESS (Street, city, town, state) <u>4812 Ellicott St NW, Washington DC</u>		DATE SIGNED <u>1-29-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/31/56</u>		NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. Mem. Com.</u>		LOCATION (City, town, or county) (State) <u>HYATTSVILLE, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Speedberg Funeral Home</u>		ADDRESS <u>4217-9th NW</u>	
DATE <u>1-31-56</u>							

CERTIFICATE OF DEATH

Reg. Dist. No. 216

823

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Mont</i>		MARYLAND		STATE <i>D.C.</i> COUNTY <i>Wash.</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Washington D.C.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburban Hospital</i>				STREET ADDRESS (If rural give location) <i>4300 Longman N.W.</i>			
3. NAME OF DECEASED: (First) <i>Jacob</i> (Middle) <i>Litman</i> (Last) <i>Litman</i>				4. DATE OF DEATH: (Month) <i>Jan.</i> (Day) <i>3</i> (Year) <i>1956</i>			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Unknown</i>	9. AGE last birthday: <i>77</i> yrs.	IF UNDER 1 YEAR: Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	IF UNDER 24 HRS.:	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Broder</i>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME: <i>Mordecai Litman</i>				14. MOTHER'S MAIDEN NAME: <i>Rebecca ?</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Alip Litman</i>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Broncho pneumonia</i>							10 DAYS
ANTECEDENT CAUSE (S) DUE TO (B) <i>Cerebral Hemorrhage</i>							17 DAYS
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Carcinomatosis, generalized</i>							6 MONTHS
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Arteriosclerotic Heart Disease</i>							18 MONTHS
19A. DATE OF OPERATION: <i>AUG. 24, 1954</i>		19B. MAJOR FINDINGS OF OPERATION: <i>CARCINOMA, COLON. HYPERNEPHROMA, RIGHT KIDNEY</i>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>JULY 9</i> , 1951, to <i>JAN 3</i> , 1956, that I last saw the deceased alive on <i>JAN. 2</i> , 1956, and that death occurred at <i>8:30 A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Robert G. Gungl M.D.</i>				ADDRESS <i>M.D. 5009 DEL Ray Ave. Bethesda, Md.</i>		DATE SIGNED <i>1/3/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1/5/56</i>		NAME OF CEMETERY OR CREMATORY <i>Adas Israel Cemetery</i>		LOCATION (City, town, or county) (State) <i>Wash. D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>11/3/56</i>		REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>		24. FUNERAL DIRECTOR <i>B. W. Gungl & Son</i>		ADDRESS <i>Wash. D.C.</i>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 5 1956

RECEIVED

824

00793

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Colorado	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Silver Spring		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Evans	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9505 Worth Avenue		STREET ADDRESS (If rural, give location) 515 Boulder Street	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) Myrtle	(Middle) Irene	(Last) Luben	(Month) Jan. (Day) 25 (Year) 19 56
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 6/9/02
9. AGE last birthday: 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): none (semi-invalid)	
11. BIRTHPLACE (State or foreign country): Terre Haute, Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Edward Luben		14. MOTHER'S MAIDEN NAME: Louise Kohlenberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: none	
17. INFORMANT & ADDRESS: Mrs. Ethel L. Oliver, 9505 Worth Ave. Silver Spring, Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) Coronary occlusion DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating <u>underlying cause last</u> (c)			sudden death
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE Frank V. Bruchman		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> 1-26-56	
23. BURIAL, CREMATION, REMOVAL (Specify): Trans. & Burial		24. FUNERAL DIRECTOR	
DATE THEREOF 1/30/56	NAME OF CEMETERY OR CREMATORY Evans Cemetery	LOCATION (City, town, or county) (State) Evans, Colorado	
DATE REC'D BY LOCAL REG. 1-26-56	REGISTRAR'S SIGNATURE Frances Potter	ADDRESS 8434 Ga. Ave. Silver Spring, Md.	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 30 1956
BUREAU A.S.

9561-06

3AM

CERTIFICATE OF DEATH

Reg. Dist. No. 216...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>4 1/2 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural give location) <u>12605 Connecticut Ave.</u>	

3. NAME OF DECEASED: (Type or Print) <u>Gaetano Lunetta</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 15 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Dec 13, 1888</u>
9. AGE last birthday: <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10B. KIND OF BUSINESS, OR INDUSTRY: <u>Kay Construction</u>	
11. BIRTHPLACE (State or foreign country): <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>CARL LUNETTA</u>		14. MOTHER'S MAIDEN NAME: <u>LOUISE CANNERATA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>189-03-1844</u>	
17. INFORMANT & ADDRESS: <u>MISS GRACE LUNETTA</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>embolism, shock</u>		<u>15 hrs</u>
ANTECEDENT CAUSE (B) <u>carcinoma of duodenum</u>		<u>6 mo</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>severe bleeding for 3 wks before death</u>	
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19A. DATE OF OPERATION: <u>1-14-56</u>	19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of duodenum</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from JAN 13, 1956, to 1-15, 1956, that I last saw the deceased alive on JAN 15, 1956, and that death occurred at 7:20 AM, from the causes and on the date stated above.

SIGNATURE <u>John O. Ralchen</u>	ADDRESS <u>Silver Spring</u>	DATE SIGNED <u>1-15-56</u>
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23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/18/56</u>	NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	LOCATION (City, town, or county) (State) <u>Montgomery Co. Md</u>
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DATE REC'D BY LOCAL REGISTRAR <u>1-16-56</u>	REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>	ADDRESS <u>8634 So Ave SSMO</u>
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 18 1892

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Virginia		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN Bethesda Rural		4 days		TOWN Falls Church		83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital				STREET ADDRESS (If rural give location) 6904 Pine Tree Terrace			
3. NAME OF DECEASED: (Type or Print)		(First) Janice		(Middle) Celeste		(Last) MANSON	
5. SEX: Female		6. COLOR OR RACE: Cauc.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		4. DATE (Month) (Day) (Year) OF DEATH: JANUARY 7 1956	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None		9. AGE last birthday: 1-3-56		11. BIRTHPLACE (State or foreign country): Maryland	
13. FATHER'S NAME: Frank Albert MANSON		14. MOTHER'S MAIDEN NAME: Orie Lee PICKREN		12. CITIZEN OF WHAT COUNTRY? U.S.		15. Was DECEASED EVER in U.S. ARMED FORCES? (Yes, no, or unk.): No	
16. SOCIAL SECURITY NO. -		17. INFORMANT & ADDRESS: Father: Frank Albert MANSON, 6904 Pine Tree Terrace, Falls Church, Virginia		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) PNEUMONIA - diffuse				2 days			
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Large inter atrial Septal defect							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3 Jan. , 1956, to 7 Jan. , 1956, that I last saw the deceased alive on 7 Jan. , 1956, and that death occurred at 12:35 PM , from the causes and on the date stated above.							
SIGNATURE H.A. PEARSON, LTJG, MC, USN U.S. Naval Hospital, NNMC, Bethesda, Md.				ADDRESS		DATE SIGNED 1-8-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-10-56		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR 1-8-56		REGISTRAR'S SIGNATURE Mary E. Carrelly		24. FUNERAL DIRECTOR Ives Funeral Home, 2847 Wilson Blvd. Arlington, Va.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 11 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00796
Reg. Dist.

No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Olney</u>		LENGTH OF STAY (in this place) <u>7 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Silver Spring (rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc.</u>				STREET ADDRESS (If rural, give location) <u>Rt 2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Charles Woodrow Marcum</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 26 19 56</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12/18/17</u>	9. AGE last birthday: <u>38</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Painter</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Worked for Contractor</u>	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Cecil Marcum</u>				14. MOTHER'S MAIDEN NAME: <u>Corda Sumpter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes</u> <u>WW #2</u>				16. SOCIAL SECURITY No.: <u>231-03-1780</u>		17. INFORMANT & ADDRESS: <u>Hospital Record</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Extra dual hemorrhage</u> DUE TO						9 days	
Antecedent cause(s) (b) <u>laceration left middle meningeal artery</u> DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>fracture of skull</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>1/20/56</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) <u>Silver Spring Montg</u> ¹⁵		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (State) <u>MD</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1-18-56</u> <u>2 P.M.</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell from ladder</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschack</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-27-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1/30/56</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REG. <u>1-28-56</u>		REGISTRAR'S SIGNATURE <u>Esther B. Lawler</u>		24. FUNERAL DIRECTOR <u>Wanner E. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

RECEIVED

FEB 1 1956

BUREAU V. S.

828

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00797

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		STATE MARYLAND		COUNTY MONTGOMERY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN SILVER SPRING				TOWN FAIRLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10,800 COLESVILLE ROAD				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) NELLIE		(Middle) ALICE		(Last) MARLOW		JAN. 29 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH		9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
FEMALE	WHITE	WIDOWED	MAY 10, 1869		86 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOMEMAKER (retired)		OWN HOME		BELTSVILLE, MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN H. ROBEY				ALEXENIA ROBEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		NONE		Mr. Fielder T. Marlow, Fairland, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
450.0 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						2-3 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						3 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1950, to Jan 29, 1956, that I last saw the deceased alive on Jan 29, 1956, and that death occurred at 6:07 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, or county)		DATE SIGNED	
William D. Anderson				10,800 Colesville Rd, Silver Spring, Md.		1/30/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
BURIAL		FEB. 1, 1956		ST. MARK'S CEMETERY		FAIRLAND, MONTGOMERY CO., MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
2/2/56		Frances Potter		Warner E. Humphrey		SILVER SPRING, MD.	
DATE							

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

829

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00798

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN RURAL Clarksburg MD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN RURAL Clarksburg MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>JAMES W. MASON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 27 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 7 1876</u>
9. AGE last birthday <u>79</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ag. Work Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Mason</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Bruce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-24279</u>	
17. INFORMANT <u>Rev. Sherman Mason</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
Immediate cause (a) Heart + Failure
Antecedent cause(s) (b) Hypertensive Cardiovascular disease
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Anterior MI

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov 1955, to 1/27, 1956, that I last saw the deceased alive on Jan 22, 1956, and that death occurred at 6:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>Jan 30 1956</u>	<u>Johns Hopkins</u>	<u>Montgomery Co MD</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan 28, 1956</u>	<u>Alfred L. Cooke</u>	<u>Roy W. Barber</u>	<u>Antietam, MD</u>	

BUREAU V. S.

JAN 21 1956

RECEIVED

724

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>—</u>		COUNTY <u>— 47X-3</u>	
CITY (If outside corporate limits, write and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
17 TOWN <u>Takoma Park</u>		5 days		TOWN <u>District of Columbia</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Washington Sanitarium + Hospital		STREET ADDRESS (If rural give location)			
75				7600 16 th St. N.W. ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Martha May McCann				DEATH: 1 1 1956			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Fe.		Cauc.		Married		1-6-81	
						9. AGE last birthday 74 yrs.	
						IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Hswf				—		Massachusetts	
13. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
Joseph J. Farwell				Amer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
No				Unk.		Hospital Records Washington Sanitarium + Hospital	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170X IMMEDIATE CAUSE		(A)		Hypostatic Pneumonia		2 days	
ANTECEDENT CAUSE (S)		DUE TO		Obstruction of Ascending Colon		?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B)		DUE TO		?	
		(C)		Scirrhous Carcinoma of " "		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Interval between ONSET AND DEATH	
2		due to " "		" Rt. breast 8 yrs ago		2 days	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 26, 1955, to Jan. 1, 1956, that I last saw the deceased alive on Dec. 30, 1955, and that death occurred at 3:30 AM, from the causes and on the date stated above.							
SIGNATURE <u>Paul V. Starr</u>				ADDRESS <u>M. D. Takoma Park, Md.</u>		DATE SIGNED <u>Jan. 1, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Jan 3 - 1956		Oak Grove Cem		Fall River, Mass.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Jan. 1st 1956		J. Wilson Wood		A. B. Riney Co., Washington, D.C.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

BUREAU V. 11

JAN 4 1956

RECEIVED

830

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Montgomery.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring.</u>	LENGTH OF STAY (in this place) <u>Some years.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>523 Dartmouth Ave.</u>		STREET ADDRESS (If rural give location) <u>523 Dartmouth Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Angelina</u>		<u>Meeks</u>	
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>col.</u>	
7. <u>SINGLE</u> MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single.</u>		8. DATE OF BIRTH: <u>Unk.</u>	
9. AGE last birthday: <u>54</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Unk.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>EILY MEEKS</u>		14. MOTHER'S MAIDEN NAME: <u>ELIZA BLAIR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Dr. Wilshire - Li 6-8080</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>420.0</u>		(A) <u>Hypertensive + Arteriosclerotic.</u>	
ANTECEDENT CAUSE (S):		DUE TO <u>Heart Disease</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Secondary Anemia.</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
O			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 19... to 19..., that I last saw the deceased alive on 19..., and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
SIGNATURE <u>Ralph Stiller</u>		ADDRESS <u>9277 Beech Drive - 11/27/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>1-30-56</u>	
NAME OF CEMETERY OR CREMATORY <u>--</u>		LOCATION (City, town, or county) (State) <u>Jetersville, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-31-56</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>	
24. FUNERAL DIRECTOR <u>W.E. Jamis Co - 1432 4th St. N.W.</u>		ADDRESS <u>178</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FILY MARKS

ELIZA BLAIR

BUREAU V. S.

FEB 2 1956

RECEIVED

U.S. Justice - 1935

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00801

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5405 Beech Ave.</u>		STREET ADDRESS (If rural, give location) <u>5405 Beech Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARIE</u>	(Middle) <u>S</u>	(Last) <u>MEEM</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>3-4-1874</u>
9. AGE last birthday <u>81</u> yrs.		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>3</u> (Year) <u>1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trade Mark Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trade Mk Bus.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>C. Edward Meems</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Moe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Harry C. Meems, Jr.</u> <u>Nephew-Dickerson, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>CHRONIC HEART FAILURE</u>			
Antecedent cause(s) (b) <u>BACTERIAL ENDOCARDITIS</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>MARCH, 1954</u> , to <u>Jan. 3, 1956</u> , that I last saw the deceased alive on <u>Jan. 3, 1956</u> , and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Robert J. Thibodeau M.D.</u>		DATE SIGNED <u>Jan 3, 1956</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-6-56</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Roses</u>		LOCATION (City, town, or county) (State) <u>Cloppers Md</u>	
DATE REC'D BY LOCAL REG. <u>1/4/56</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JAN 9 1951

RECEIVED

725
CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

COUNTY MONTGOMERY MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK, MD. LENGTH OF STAY (in this place) 11 mos.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 700 Hudson Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE M.D. COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) Cherry Chase.
 STREET ADDRESS (If rural, give location) 6815 Georgia Ave.

3. NAME OF DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

CLARISSAMELGAARD

4. DATE OF DEATH:

(Month)

(Day)

(Year)

JAN. 11956

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

FWWIDOWEDAUG. 28, 188075 yrs.

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

NoNoNone.Mrs. Agnes Arnold6815 Georgia Ave. Cherry Chase, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

450.0

Immediate cause

(a)

DUE TO

Chronic Heart Failure

INTERVAL BETWEEN ONSET AND DEATH

1 year

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

Atherosclerosis, General5 years

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 28, 1955, to Jan. 1, 1956, that I last saw the deceased alive on Jan. 1, 1956, and that death occurred at 6:15 p.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

James A. Roberts M.D.8907 Georgia Ave. Silver Spring, Md.Jan. 1, 1956.

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 1-1956J. Wilson DoddW. H. Jones Co., Washington D.C.Ad

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 4 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>DC</u>	COUNTY <u>47X-3</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
17 TOWN <u>Takoma Park</u>	<u>79 days</u>	TOWN <u>Washington 16 D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
75 <u>Washington San + Hosp. al</u>		<u>4814 Sedgwick St. N.W.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Mabel</u>	(Middle) <u>Louise</u>	(Last) <u>Mercer</u>	(Month) <u>1</u> (Day) <u>5</u> (Year) <u>1956</u>
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>wh. re</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>	8. DATE OF BIRTH: <u>2-8-76</u>
9. AGE last birthday <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>5</u> Hours <u>19</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		12. KIND OF BUSINESS OR INDUSTRY:	
13. FATHER'S NAME: <u>Francis Vaughn</u>		14. MOTHER'S MAIDEN NAME: <u>Louisa Flint</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS: <u>Daughter - Wash. San + Hosp. records</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>Hypertensive Cardiovascular Dis. w/ Decompensation</u>		15 yrs.	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
0			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 29, 1955</u> to <u>Jan 5, 1956</u> that I last saw the deceased alive on <u>Jan 5, 1956</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. M. O'Neil</u>		ADDRESS <u>M. D. Takoma Park, 12, Md. 1-5-56</u>	
DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		LOCATION (City, town, or county) (State)	
<u>Burial - 1-7-56 Rock Creek Cemetery</u>		<u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>Jan 5 1956</u>		<u>J. H. Hines Co</u>	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>J. M. O'Neil</u>		<u>2901 14th NW</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 10 1956

RECEIVED

832

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Calvert
CITY (If outside corporate limits, write RURAL or TOWN and give nearest town) Bethesda Rural	LENGTH OF STAY (in this place) 2 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North Beach	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural give location) 416 Frederick Avenue	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Arthur	(Middle) Walter	(Last) METZGER	OF DEATH: January 20 1956
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 6-12-92
9. AGE last birthday 63 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	10B. KIND OF BUSINESS OR INDUSTRY: Maintenance	11. BIRTHPLACE (State or foreign country): Virginia	12. CITIZEN OF WHAT COUNTRY? US
--	---	--	--

13. FATHER'S NAME: Harry C. METZGER	14. MOTHER'S MAIDEN NAME: Harriet STROBERT
--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) Yes (If Yes, give war or dates of service) WW I	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT & ADDRESS: Sister Mrs. Angie MARGERUM Same as above
---	--	--

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	Coronary occlusion	Immediate
IMMEDIATE CAUSE (A) Myocardial Infarction	DUE TO	10 days
ANTECEDENT CAUSE (S) Arteriosclerotic heart disease	(B) DUE TO	5 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
-------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **18 Jan., 1956**, to **20 Jan., 1956**, that I last saw the deceased alive on **20 Jan 1956**, and that death occurred at **11:20 AM** from the causes and on the date stated above.

SIGNATURE **J. T. Horgan** ADDRESS DATE SIGNED

J. T. HORGAN LT, MC, USN U. S. Naval Hospital, NMMC, Bethesda, Maryland

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 24 Jan 1956	NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	LOCATION (City, town, or county) (State) Arlington, Virginia
--	---------------------------------	--	---

DATE REC'D BY LOCAL REGISTRAR 21 Jan 1956	REGISTRAR'S SIGNATURE Mary E. Casella	24. FUNERAL DIRECTOR ADDRESS Lee Funeral Home 4th and Massachusetts Avenue NW Wash D.C.
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 27 1956

RECEIVED

833

CERTIFICATE OF DEATH

Reg. Dist. No. *257*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Pk. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Olney</u>		LENGTH OF STAY (in this place) <u>11 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laurel</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Montgomery County General Hospital, Inc.</u>				STREET ADDRESS (If rural give location) <u>R#2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Emily Louise Miles</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>January 28 1956</u>			
5. SEX: <u>female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH: <u>6/9/68</u>	
9. AGE last birthday <u>87</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Same</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Frederick Renn</u>				14. MOTHER'S MAIDEN NAME: <u>Katherine</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>422.2</u>				(A) DUE TO <u>Congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO <u>Chronic myocarditis</u>		<u>5 yrs</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>Jan</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 27</u> , 19 <u>56</u> , and that death occurred at <u>1:50a.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. Bonifant</u>		ADDRESS <u>M. D. Sandy Spring Md</u>		DATE SIGNED <u>1/28/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>January 30 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 30 - 56</u>		REGISTRAR'S SIGNATURE <u>Eutude B Fowler</u>		24. FUNERAL DIRECTOR <u>Dr. Witt, Donaldson, Laurel, Md.</u>		ADDRESS	

BUREAU V. S.

FEB 9 1956

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

834

CERTIFICATE OF DEATH

00805

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		STATE MARYLAND		COUNTY MONTGOMERY			
CITY (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 628 SLIGO AVENUE				STREET ADDRESS (If rural give location) 628 SLIGO AVENUE			
3. NAME OF DECEASED (Type or Print) MARGARET (First) ELLEN (Middle) MILLER (Last)				4. DATE OF DEATH (Month) (Day) (Year) JAN. 25 19 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MARCH 5, 1891	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR (Month) (Day) (Year) IF UNDER 24 HRS. (Hours) (Min.)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES PRESTON BARNS				14. MOTHER'S MAIDEN NAME ANNIE ROBEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MRS. LeROY AYERS, 628 SLIGO AVE. SILVER SPRING, MARYLAND			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
454X IMMEDIATE CAUSE (A) Pulmonary Embolus						INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Pulmonary Thrombosis						None	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 18, 1956, to Jan. 25, 1956, that I last saw the deceased alive on Jan. 24, 1956, and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
SIGNATURE <i>John R. Rogers</i>				DATE SIGNED 1919		ADDRESS (Street, city, town, state) Silver Spring, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 1/28/56		NAME OF CEMETERY OR CREMATORY COLESVILLE CEMETERY		LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Frances Potter</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>			
DATE 1-31-56				ADDRESS SILVER SPRING, MD.			

CERTIFICATE OF DEATH

UNIVERSITY STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

For Use No.

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. RACE

5. DATE OF BIRTH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. PLACE OF DEATH

12. NAME OF PHYSICIAN

13. NAME OF FUNERAL HOME

14. NAME OF BURIAL PLACE

15. NAME OF NEXT OF KIN

16. NAME OF WITNESS

17. NAME OF SIGNER

18. NAME OF SIGNER

19. NAME OF SIGNER

20. NAME OF SIGNER

21. NAME OF SIGNER

22. NAME OF SIGNER

23. NAME OF SIGNER

24. NAME OF SIGNER

25. NAME OF SIGNER

26. NAME OF SIGNER

27. NAME OF SIGNER

28. NAME OF SIGNER

29. NAME OF SIGNER

30. NAME OF SIGNER

31. NAME OF SIGNER

32. NAME OF SIGNER

33. NAME OF SIGNER

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43. NAME OF SIGNER

44. NAME OF SIGNER

45. NAME OF SIGNER

46. NAME OF SIGNER

47. NAME OF SIGNER

48. NAME OF SIGNER

49. NAME OF SIGNER

50. NAME OF SIGNER

BUREAU V. S.

FEB 2 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00806

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u> <u>Fred.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>24 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	<u>10/11-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Maryland</u>		STREET ADDRESS (If rural give location) <u>731 North Market Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Virginia H. Miller</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 6,</u> <u>1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>January 13, 1903</u>
9. AGE last birthday <u>52</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housekeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME: <u>J. Marshall Miller</u>		14. MOTHER'S MAIDEN NAME: <u>Fannie Harling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Hepatic Coma and Hypertension</u>			<u>1 week</u>
ANTECEDENT CAUSE (B) <u>Carcinoma of Breast with metastases</u>			<u>1 1/2 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>3 Oct. 18, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Adrenal metastases. Oophorectomy, appendectomy and bilateral adrenalectomy.</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 13, 1955</u> to <u>Jan. 6, 1956</u> that I last saw the deceased alive on <u>Jan. 6, 1956</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above			
SIGNATURE <u>Richard B. Paton</u>		DATE SIGNED <u>11/6/56</u>	
M. D. <u>The Clinical Center, NIH, Bethesda, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/9/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		LOCATION (City, town, or county) (State) <u>Frederick Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8 Jan. 1956</u>		24. FUNERAL DIRECTOR ADDRESS <u>H. E. Early Co Frederick Md</u>	

RECEIVED

JAN 11 1956

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

836

00807

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Prince George</u>		CITY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
X TOWN <u>Seneca</u>		<u>3 months</u>		TOWN <u>Indian Head</u>		<u>08X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Marylander Rest Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Catherine</u> (Middle) <u>H.</u> (Last) <u>Milstead</u>				(Month) <u>Jan</u> (Day) <u>29</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>July 26, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Bowie</u>				14. MOTHER'S MAIDEN NAME <u>Ella Huffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Earl Milstead Indian Head, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
199.9 IMMEDIATE CAUSE (A) <u>Hypostatic pneumonia</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinomatous</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes mellitus</u>						<u>3 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>23 Nov</u> , 19 <u>55</u> , to <u>29 Jan</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>28 Jan</u> , 19 <u>56</u> , and that death occurred at <u>9:15 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>John S. Lawrence</u> M.D.				DATE SIGNED <u>P.O. Boyd Maryland 29 Jan 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>231556</u>		<u>1/29/56</u>		<u>Memorial Cemetery</u>		<u>Persimmon Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan 31/56</u>		<u>Charles L. Cooke</u>		<u>Prepared Funeral Home Inc</u>		<u>Lupton Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

FEB 2 1955

RECEIVED

837

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>47X-3</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>24 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		<u>D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Resmor Hospital</u>				STREET ADDRESS (If rural give location) <u>2131 0st. N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>MARY JANE MOORE</u>				<u>JANUARY 13 1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>2/14/1911</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Gov't work</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Gov't.</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Edwin Moore</u>				14. MOTHER'S MAIDEN NAME: <u>Mildred Lynn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Teresa O'Brien-2131 0st. N.W. - D.C.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial infarct</u>						<u>5 weeks.</u>	
ANTECEDENT CAUSE (B) <u>senility, general debility</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>a recent fracture left hip & carcinoma of breast</u>						<u>remitted 11/27</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 6, 1955</u> to <u>Jan. 13, 1956</u> (that I last saw the deceased alive on <u>Jan. 12, 1956</u> , and that death occurred at <u>10⁴⁵ AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John J. Dolan</u>		M. D. <u>3100 Conn Ave</u>		DATE SIGNED <u>1/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/16</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-16-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>2900 14th St N.W.</u> ADDRESS <u>WASHINGTON D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Reported to & approved by the
Montgomery County Medical Examiner.
John V. Dolan M.D.

RECEIVED

JAN 18 1950

BUREAU V. S.

838

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00809

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL or and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 9hrs 10 min		CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 7005 Exeter Road			
3. NAME OF DECEASED: (First) Gail		(Middle) Whitney		(Last) MUFFITT		4. DATE (Month) (Day) (Year) OF DEATH: January 5 1956	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single	8. DATE OF BIRTH: 7-21-55		9. AGE last birthday: 5 yrs.		IF UNDER 1 YEAR: 13 Months 13 Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Dempster MUFFITT				14. MOTHER'S MAIDEN NAME: Jean GELENIUS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. - -		17. INFORMANT & ADDRESS: Father Dempster MUFFITT HMC USN Same as above			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 492X Interstitial pneumonia						10 hours	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: (1) Meningismus (2) Cardiac dilatation							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4 Jan , 19 56 , to 5 Jan , 19 56 , that I last saw the deceased alive on 5 Jan , 19 56 , and that death occurred at 5:55A , M, from the causes and on the date stated above.							
SIGNATURE R. L. S. BAIRD		ADDRESS U. S. Naval Hospital, NMMC, Bethesda, Maryland		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9 Jan 1956		NAME OF CEMETERY OR CREMATORY Private Cemetery		LOCATION (City, town, or county) (State) Hillsdale, Michigan	
DATE REC'D BY LOCAL REGISTRAR 5 Jan 1956		REGISTRAR'S SIGNATURE Mary E. Carrelly		24. FUNERAL DIRECTOR R. A. Humphrey Funeral Home		ADDRESS 7557 Wisconsin Avenue, Bethesda, Md.	

MARGIN RESERVED FOR BINDING

VS. A15 - 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2051292396

BUREAU V. S.

JAN 11 1956

RECEIVED

839

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNT Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Olney		LENGTH OF STAY (in this place) 2 days		CITY (If outside corporate limits, write RURAL and give nearest town) Rural - Kemptown		10X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery County Gen. Hospital				STREET ADDRESS (If rural give location) R.F.D. Mt. Airy			
3. NAME OF DECEASED: (First) Annie		(Middle) -		(Last) Mullinix		4. DATE OF DEATH: (Month) Jan. (Day) 17 (Year) 19 56	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: March 1, 1889		9. AGE last birthday: 66 yrs. Months Days Hours Min.		
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY: Own Home		11. BIRTHPLACE (State or foreign country): Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Basil F. Buxton				14. MOTHER'S MAIDEN NAME: Louisa H. Moxley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mrs Ellsworth Mullinix, Mt. Airy, Md.			
18. MEDICAL CERTIFICATION						Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X Immediate cause (a) Hypertensive Heart Disease						5 years	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) with terminal irreversible congestive heart failure.							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchial Asthma							
19a. DATE OF OPERATION: none				19b. MAJOR FINDINGS OF OPERATION: none			
20. AUTOPSY? No							
21. ACCIDENT SUICIDE HOMICIDE (Specify) No		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 1935, to January 17, 1956 that I last saw the deceased alive on Jan 17 1956, and that death occurred at 10:00 PM, from the causes and on the date stated above.							
SIGNATURE M. McKendree Boyer				ADDRESS Druid Theatre Building Damascus 1/19/56			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Jan. 20, 1956		NAME OF CEMETERY OR CREMATORY Providence Cemetery		LOCATION (City, County, State) Kemtown, Md.	
DATE REC'D BY LOCAL REGISTRAR 1-23-56		REGISTRAR'S SIGNATURE Gertrude B. Lawler		24. FUNERAL DIRECTOR Olin L. Molesworth		ADDRESS Damascus, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 25 1934

RECEIVED

840

CERTIFICATE OF DEATH

Reg. Dist. No. 213

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural Rockville</u>		LENGTH OF STAY (in this place) <u>20 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) <u>JOHN</u> (Middle) <u>P</u> (Last) <u>MYERS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan.</u> <u>14</u> <u>19 56</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Nov. 21 1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Adminis. Asst. Coast Gdard Gov.</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>John P. Myers Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Isabel Luther</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>Wife-Babette C. Myers, RFD#4, Rockville</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Respiratory failure</u>						<u>15 min.</u>	
ANTECEDENT CAUSE (B) <u>metastatic carcinoma</u>						<u>6 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Reprints - carcinoma of mammary</u>						<u>10 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION: <u>Reprints - carcinoma c metastases</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/1/52</u> , 19 <u>52</u> , to <u>1/14/56</u> , 19 <u>56</u> that I last saw the deceased alive on <u>1/14/56</u> , 19 <u>56</u> , and that death occurred at <u>8:00 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stephen R. Jones M.D.</u>		M. D. <u>Rockville Md</u>		DATE SIGNED <u>1/16/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>1-17-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Prince Georges Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/7/56</u>		REGISTRAR'S SIGNATURE <u>Laurell W. Bengtson</u>		24. FUNERAL DIRECTOR <u>Robt. R. Lumsden</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

FEB 8 1956

RECEIVED

841

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda		LENGTH OF STAY (in this place) 67 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR Bethesda			
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center Bethesda, Maryland				STREET ADDRESS (If rural give location) 5524 Oakmont Avenue			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) Mary		(Middle) Hiley		(Last) Nasuti		DATE: Jan. 8, 1956	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Widowed	February 5, 1899	56 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		
					Alabama		
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Eugene Hiley				Mary E. Matthews			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
No				Not available		The Medical Record, The Clinical Center	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Adhesive Pericarditis							weeks
ANTECEDENT CAUSE (B) Metastatic Carcinoma, lungs and mediastinum							5 months
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Carcinoma, left breast							3 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
2							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
none							
22. I hereby certify that I attended the deceased from Nov. 2, 1955, to Jan. 8, 1956, that I last saw the deceased alive on Jan. 8, 1956, and that death occurred at 6:04 PM, from the causes and on the date stated above.							
SIGNATURE Herbert A. Lusk				ADDRESS The Clinical Center National Cancer Institute DATE SIGNED 1/9/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1-12-56		Arlington National		Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
1/12/56		Bessie M. Thompson		Robert A. Bunnell		Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 16 1896

RECEIVED

842

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY.</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY.</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)				CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>BETHESDA 14, MD.</u> LENGTH OF STAY (in this place) <u>10 YRS.</u>				TOWN <u>BETHESDA 14, MD.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>NONE.</u>				STREET ADDRESS (If rural give location) <u>9217 ADELAIDE DRIVE.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>PAUL HOWARD NETTLETON.</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>JANUARY 1, 1956.</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED.</u>		8. DATE OF BIRTH: <u>AUGUST 27, 1908</u>	
9. AGE last birthday <u>47</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>GOVERNMENT ANALYST</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. GOVERNMENT.</u>		11. BIRTHPLACE (State or foreign country): <u>MINNESOTA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME: <u>GEORGE HOWARD NETTLETON.</u>				14. MOTHER'S MAIDEN NAME: <u>ELEANOR SHEEHAN.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO.</u>				16. SOCIAL SECURITY No. <u>? NO</u>		17. INFORMANT & ADDRESS: <u>JOAN KATHRYN RAMSAY, 316 MT. VERNON PL. ROCKVILLE, MD</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						DAUGHTER.	
IMMEDIATE CAUSE (A) <u>ACUTE CORONARY OCCLUSION.</u>						5 MINUTES	
ANTECEDENT CAUSE (S) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>						6 MOS.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE.</u>							
19A. DATE OF OPERATION: <u>NONE.</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR? <u>—</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW OLD INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>January 1, 1956</u> , to <u>January 1, 1956</u> , that I last saw the deceased alive on <u>January 1, 1956</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Signatur Greenbaum,</u>				ADDRESS <u>M. O. 9300 EWINO DR. BETHESDA 14, MD. 1/2/56.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/4/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		LOCATION (City, town, or county) (State) <u>Rockville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 3-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR ADDRESS <u>Robert A. Humphrey Bethesda, Md.</u>			

Spoke with Deputy Coroner Dr. John
Ball per telephone approximately 15 minutes after
demise of patient. He gave permission for
release of body to undertaker.

1/2/56.

Seymour Granbaum, M.D.

BUREAU V. 3

JAN 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park LENGTH OF STAY (in this place) 6 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington San. & Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE District of Columbia COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington 47X-3

STREET ADDRESS (If rural give location) 1443 Spring Rd., N.W.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print) Fred (None) Niccum

4. DATE (Month) (Day) (Year)

OF DEATH: 1 27 1956

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MaleWhiteMarried 10-12-8570 yrs.MonthsDaysHours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X

IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE (S)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

several yrs3-4 yrsday

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1953, 19....., to 1/27/56, that I last saw the deceased

alive on 1/27/56, 1956 and that death occurred at 5:45 P. M., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

M. D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

TRANSIT BURIAL1-30-56CONVERSEINDIANA.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 27-1956J. M. M. DoddThe S. H. M. Co 2901 14th St N.W. Wash. D.C.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 31 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00814

843

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		LENGTH OF STAY (in this place) <u>1 yr.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg,</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mont. General Hospital, Inc.</u>				STREET ADDRESS (If rural give location) <u>Route #1</u>		<u>1</u>	
3. NAME OF DECEASED: (First) <u>Bradley</u> (Middle) <u>Johnson</u> (Last) <u>Nichols, Jr.</u>				4. DATE (Month) <u>1</u> (Day) <u>20</u> (Year) <u>19 56</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>2/8/54</u>	
9. AGE last birthday: <u>1</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>20</u> Hours <u>19</u> Min. <u>56</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME: <u>Bradley Johnson Nichols, Sr.</u>		14. MOTHER'S MAIDEN NAME: <u>Virgie Redmond</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE CAUSE (A) <u>Pneumonia - Ecto.</u>		ANTECEDENT CAUSE (B) <u>undetermined.</u>		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>Jan. 17, 1956</u> , to <u>Jan. 20 1956</u> , that I last saw the deceased alive on <u>Jan. 20, 1956</u> , and that death occurred at <u>4:25</u> M. from the causes and on the date stated above.		SIGNATURE <u>Jack Summacker</u> DATE SIGNED <u>1-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>Jan. 23 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Wheatonville Md</u>		LOCATION (City, town, or county) (State) <u>Wheatonville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-21-56</u>		REGISTRAR'S SIGNATURE <u>Certitude B. Lawler</u>		24. FUNERAL DIRECTOR <u>Ray W. Barber</u>		ADDRESS <u>Wheatonville Md</u>	

RECEIVED

JAN 25 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00815

844

CERTIFICATE OF DEATH

Reg. Dist. No. 276

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Bethesda</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4526 Avondale Street</u>				STREET ADDRESS (If rural give location) <u>4526 Avondale Street</u>			
3. NAME OF DECEASED: (First) <u>Sarah</u>		(Middle)		(Last) <u>NITZ</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>January 18</u> <u>19 56</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Mch 16, 1869</u>		9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>- - - - -</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Lena Morris--Same Item #2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma - undetermined origin</u>						<u>6 months</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 18, 1956</u> , to <u>Jan 18, 1956</u> , that I last saw the deceased alive on <u>January 18, 1956</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. E. J. Fowler</u>		M. D. <u>Bethesda 14 md</u>		DATE SIGNED <u>Jan 18, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 21, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Edgewood</u>		LOCATION (City, town, or county) (State) <u>Mt. Horeb Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/20/56</u>		REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. S.

JAN 24 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

845

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 008196

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND	CITY (If outside corporate limits, write OR and give nearest town) <u>Bethesda</u>	STATE <u>Md.</u> COUNTY <u>Mont.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u> 56
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp</u>	LENGTH OF STAY (in this place) <u>10 min.</u>	STREET ADDRESS (If rural give location) <u>2406 Churchill Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Shirley Morris Oehmann</u>		OF DEATH: <u>Jan. 3</u> 19 <u>56</u>	
5. SEX: <u>Female</u> COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 4, 1920</u>	9. AGE last birthday <u>35</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>	11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME: <u>Andrew J. Morris</u>		14. MOTHER'S MAIDEN NAME: <u>Frances McEnaney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-12-5576</u>	
17. INFORMANT & ADDRESS: <u>Andrew F. Oehmann - above</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Diabetic Coma</u>			<u>2 hrs</u>
ANTECEDENT CAUSE (B) <u>Diabetic Acidosis</u>			<u>10 hrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>			<u>12 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY <u>street office bldg., etc.</u>	
21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>27 Dec 55</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 1950</u> , to <u>3 Jan 56</u> , that I last saw the deceased alive on <u>27 Dec 55</u> , and that death occurred at <u>8:55 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Merita J. White</u> M.D. <u>11134 Georgia Ave Silver Spring</u>		DATE SIGNED <u>3 Jan 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/6/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/11/56</u>		REGISTRAR'S SIGNATURE <u>Beau Thompson</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

BUREAU V. S.

JAN 9 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

846
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00817

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Glen Echo Heights</u>				TOWN <u>Glen Echo Heights</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5404 Waneta Road</u>				STREET ADDRESS (If rural, give location) <u>5404 Waneta Road</u>			
3. NAME OF DECEASED: (First) <u>William</u>		(Middle) <u>C.</u>		(Last) <u>OLIVEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 7 19 56</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Oct. 12, 1955</u>	
9. AGE last birthday: <u>0</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Herbert M. Olivey</u>				14. MOTHER'S MAIDEN NAME: <u>Betty Jane Nagle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Same as Item #2 Mrs. Betty J. Olivey</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Respiratory Insufficiency</u> DUE TO						<u>20 min.</u>	
Antecedent cause(s) (b) <u>Virid P. pneumonia</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>2 days.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		21d. (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John B. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Jan 7, 1956</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial-Transit</u>		DATE THEREOF <u>1-9-56</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Chemung County, New York</u>	
DATE REC'D BY LOCAL REG. <u>1/9/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

9VVVVVVX-V

BUREAU V. 31

JAN 11 1936

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Montgomery</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Takoma Park</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1814 Garland Ave</i>				STREET ADDRESS (If rural give location) <i>7814 Garland Ave</i>			
3. NAME OF DECEASED: (First) <i>Harriet</i> (Middle) (Last) <i>Owen</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>JAN 5 1956</i>			
5. SEX: <i>F</i>		6. COLOR OR RACE: <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>		8. DATE OF BIRTH: <i>AUG 29, 1864</i>	
9. AGE last birthday: <i>91</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): <i>ENGLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10A. USUAL OCCUPATION (Give kind of work done during normal working life) <i>OPERATED TOWN ROAMING (RETIRED)</i>				10B. KIND OF BUSINESS OWNER OR INDUSTRY: <i>ROOMING HOUSE</i>			
13. FATHER'S NAME: <i>UNKNOWN</i>				14. MOTHER'S MAIDEN NAME: <i>UNKNOWN</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) <i>No</i> If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT & ADDRESS: <i>JAMES B. PARKHILL, 326 NORTHWEST DRIVE SILVER SPRING, Md.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>420.1</i> (A) <i>Acute Coronary Thrombosis</i> DUE TO						<i>1-2 hrs.</i>	
ANTECEDENT CAUSE (S) (B) <i>Senile Arteriosclerosis</i> DUE TO						<i>20 yrs.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>JAN 5, 1956</i> , to <i>5 Jan, 1956</i> , that I last saw the deceased alive on <i>5-Dec</i> , 19 <i>55</i> , and that death occurred at <i>8 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>J B Queen</i> ADDRESS <i>7112 Willow Ave Takoma Park</i> DATE SIGNED <i>5 JAN 1956</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>		DATE THEREOF <i>JAN. 7, 1956</i>		NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CREMATORY</i>		LOCATION (City, town, or county) (State) <i>P.AVE. EXT., PGED. CO. MD.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Jan. 5-1956</i>		REGISTRAR'S SIGNATURE <i>J. W. Chan Dodd</i>		24. FUNERAL DIRECTOR <i>J. Arthur Walters</i>		ADDRESS <i>254 S. Carroll St. D.C.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Miss Owen was found dead by neighbors this A.M. Since she was 91 and had advanced arteriosclerosis with coronary insufficiency, I feel she had an unquestionable coronary heart attack. Medical examiner Dr. John Bell notified and permission granted for me to sign this certificate.

J. H. Green (M.D.)

BUREAU V. S.

JAN 10 1956

RECEIVED

MARYLAND

847

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cedarcroft Sanitarium</u>		STREET ADDRESS (If rural, give location) <u>Lincoln Park</u>	
3. NAME OF DECEASED (First) <u>Ernest</u> (Middle) <u>A.</u> (Last) <u>Palmer, Jr.</u>		4. DATE OF DEATH <u>January 7</u> 19 <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 27, 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Ernest Palmer Sr</u>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs Ellen Palmer Rockville, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>asphyxiation from aspiration of vomitus</u>		Antecedent cause(s) <u>alephism bringing on vomiting, diarrhea from gastro-enteritis.</u>		<u>Several days</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Patient had alcoholic hallucinosis</u>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-6, 1956 to 1-7, 1956 that I last saw the deceased

alive on 1-7, 1956 and that death occurred at 12:45 P. from the causes and on the date stated above.

SIGNATURE Elvin J. Kistler M.D. (Deputy or title) ADDRESS Cedarcroft Sanitarium DATE SIGNED 1/10/56

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 1/10/56 NAME OF CEMETERY OR CREMATORY Lincoln Park. LOCATION (City, town, or county) (State) Rockville, Md.

DATE REC'D BY LOCAL REG. 1/10/56 REGISTRAR'S SIGNATURE Laurel H. Bryant 24. FUNERAL DIRECTOR Robert L. Sworden ADDRESS Rockville, Md.

MARGIN RESERVED FOR BINDING

BUREAU V S
BUREAU

JAN 11 1956
JAN 11

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write and give nearest town)			
OR TOWN <u>Takoma Park</u>		<u>1 hr 20 min</u>		OR TOWN <u>Landover</u>		<u>16X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hospital</u>				STREET ADDRESS (If rural give location) <u>3709 Harmond Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Armand Stephen Pattago</u>				<u>1 - 1 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>5-24-1912</u>	
9. AGE last birthday <u>43</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Months		Days		Hours		Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Policeman</u>				10B. KIND OF BUSINESS, JOB, OR INDUSTRY: <u>Hopkins University</u>		11. BIRTHPLACE (State or foreign country): <u>Maine</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>				13. FATHER'S NAME: <u>John G. Pattago</u>			
14. MOTHER'S MAIDEN NAME: <u>Aurora D. Champlain</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW2</u>			
16. SOCIAL SECURITY NO. <u>Unk.</u>				17. INFORMANT & ADDRESS: <u>Hospital Records Washington Sanitarium & Hospital.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1 Acute myocardial infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>			
ANTECEDENT CAUSE (B) <u>Coronary atherosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>December 31, 1955</u> , to <u>January 1, 1956</u> , that I last saw the deceased alive on <u>January 1, 1956</u> , and that death occurred at <u>12³⁰ AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Bennet A. Porter, M.D.</u>				ADDRESS <u>M. D. 9301 Coleridge Rd., Silver Spring, Md.</u>			
DATE SIGNED <u>January 1, 1956</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEM.</u>		LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 1 - 1956</u>		REGISTRAR'S SIGNATURE <u>J. Wilson Deeds</u>		24. FUNERAL DIRECTOR <u>W.W. Chambers Co-Riverdale, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Broschart contacted by Dr. Porter
Approval given.
m. Darrell R. K.

BUREAU V. S.

JAN 4 1956

RECEIVED

848 Item 1, Film 9192 1-30-56 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00821
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 217

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Blenny</u>	<u>SEA</u>	TOWN <u>Manor Club, Rockville</u>	<u>26</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Monty Co. Gen Hosp</u>		STREET ADDRESS (If rural, give location)	
		<u>1427 Crossway Road</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Frank</u>	(Middle) <u>A.</u>	(Last) <u>Pellegrini</u>	(Month) <u>January</u> (Day) <u>14</u> (Year) <u>1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Nov. 7, 1904</u>
9. AGE last birthday: <u>51</u> yrs.		10. IF UNDER 1 YEAR: <u>19</u> Months <u>55</u> Days <u>56</u> Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Butte, Montana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Constant Pellegrini</u>		14. MOTHER'S MAIDEN NAME: <u>Theresa Primavera</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>WW #2</u>		16. SOCIAL SECURITY NO.: <u>579-48-1690</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Rena S. Pellegrini, 1427 Crossway Rd.</u>			
18. MEDICAL CERTIFICATION		Interval Between Onset and Death	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <u>Coronary occlusion</u>			
DUE TO			
Antecedent cause(s) (b)			
Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Broschant</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-14-56</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Trans. & Burial</u>	DATE THEREOF: <u>1/19/56</u>	NAME OF CEMETERY OR CREMATORY: <u>Calvary Cemetery</u>	
LOCATION (City, town, or county) (State): <u>Seattle, King County, Washington</u>			
DATE REC'D BY LOCAL REG. <u>Jan 15-56</u>	REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>	24. FUNERAL DIRECTOR <u>Wanner & Humphrey</u>	
ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 19 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

849

CERTIFICATE OF DEATH

Reg. Dist. No. 00822 13

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Bethesda</u>		<u>1 wk. 1 day</u>		TOWN <u>Washington 28, 16X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp</u>				STREET ADDRESS (If rural give location) <u>7520 Marlboro Pike</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Josephine Peterson</u>				<u>Jan 8 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>		<u>Dec. 17, 1869</u>	<u>86</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Brooklyn, New York</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Armstrong</u>				<u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<u>Frieda Wood - Sister-in-law</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>332X</u>							
(A) <u>Massive cerebral infarction</u>						<u>? days</u>	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>Arteriosclerosis, Cerebral</u>						<u>? years</u>	
(C) <u>Senility</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Bronchopneumonia, left lower lobe</u>						<u>? days</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3.1 Dec, 1953</u> , to <u>8 Jan</u> , 1956, that I last saw the deceased alive on <u>8 Jan</u> , 1956, and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Blush</u>		<u>M. D. Suburban Hosp. Bethesda Md.</u>		<u>9 Jan 58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-11-56</u>		<u>Int. Calvary</u>		<u>Forestville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1/9/56</u>		<u>Bessie M. Thompson</u>		<u>Robert A. Mattingly</u>		<u>131-14 St. N.E. Wash. D.C.</u>	

BUREAU V. S.

JAN 11 1956

RECEIVED

850

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>New York</u>	COUNTY <u>--</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>91 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Scarsdale</u>	<u>69X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Maryland</u>		STREET ADDRESS (If rural give location) <u>53 Fayette Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Fred erick Norman Polangin</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 3, 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 13, 1913</u>
9. AGE last birthday <u>42</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Advertising</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Advertising</u>	
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>William Polangin</u>		14. MOTHER'S MAIDEN NAME: <u>Sophie Cransfield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes W.W. II</u>		16. SOCIAL SECURITY No. <u>Not available</u>	
17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Sepsis & gas gangrene of internal organs</u>			
ANTECEDENT CAUSE (S) (B) <u>Acute appendicitis & localized peritonitis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Acute granulocytic leukemia</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2 none</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Oct. 4, 1955</u> , to <u>Jan. 3, 1956</u> , that I last saw the deceased alive on <u>Jan. 3, 1956</u> , and that death occurred at <u>8:40 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Robert J. Levine</u>		M. D. ADDRESS DATE SIGNED <u>1/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>1-4-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Beth Isreal</u>		LOCATION (City, town, or county) (State) <u>Mercer Co. Pennsylvania</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/4/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert A. Campbell</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 9 1956

RECEIVED

851

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Brentwood, Md.</u> <u>16-34-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Md.</u>				STREET ADDRESS (If rural give location) <u>4309 39th Place</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Louis Anthony Post, Jr.</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 26, 19 56</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 28, 1910</u>	9. AGE last birthday <u>45</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Warehouse Mgr. Warehousing</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Mass.</u>		11. BIRTHPLACE (State or foreign country): <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Louis A. Post</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Emerson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>Yes</u> <u>W.W. II</u>				16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage.</u>						<u>3 hours.</u>	
ANTECEDENT CAUSE (B) <u>Acute myelogenous leukemia</u>						<u>1 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2 None</u>				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan. 26, 1956</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>Jan. 25, 1956</u> , to <u>Jan. 26, 19 56</u> that I last saw the deceased alive on <u>Jan. 26</u> , 1956, and that death occurred at <u>11:12 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Bernard R. Landon</u>				ADDRESS <u>M. D. The Clinical Center, NIH Bethesda, Md.</u>		DATE SIGNED <u>1/27/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/30/1956</u>		NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATI CON</u>		LOCATION (City, town, or county) (State) <u>ARLINGTON Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-30-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>W. W. CHAMBERS Co - Riverdale, Mo</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 2 1956

RECEIVED

852

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Louisiana</u>		COUNTY <u>--</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>39 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>New Orleans</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Maryland</u>				STREET ADDRESS (If rural give location) <u>17 North Hawk Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Rose Ann Randazzo</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>January 5, 1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>April 30, 1913</u>	9. AGE last birthday <u>42</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>S.W. Bell Telephone</u>		11. BIRTHPLACE (State or foreign country): <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Vincent Randazzo</u>				14. MOTHER'S MAIDEN NAME: <u>Marie DiMarco</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Widespread metastases</u>							
ANTECEDENT CAUSE (B) <u>Carcinoma of the breast spreading to</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Ulcer ulcer in 1st portion of duodenum</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 27, 1955</u> to <u>Jan. 5, 1956</u> , that I last saw the deceased alive on <u>Jan. 5, 1956</u> , and that death occurred at <u>9:47 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Richard S. Frit</u>		ADDRESS <u>M. D. The Clinical Center, NIH, Bethesda, Md.</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>1-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>Metairie</u>		LOCATION (City, town, or county) (State) <u>New Orleans, La.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/9/56</u>		REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>		FUNERAL DIRECTOR <u>Robert M. Thompson</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 11 1956

BUREAU V. S.

730

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	OR TOWN <u>17</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Sanitarium Hospital</u>		STREET ADDRESS (If rural give location) <u>509 Philadelphia</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>Jessie</u>	(Middle) <u>Everett</u>	(Last) <u>Reader</u>	<u>1-1-1956</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W. Dow.</u>	8. DATE OF BIRTH: <u>F. 22-27</u>
9. AGE last birthday <u>75</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>28</u>	
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Abram Baker</u>		14. MOTHER'S MAIDEN NAME: <u>Hucy Everett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>-</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Massive Myocardial Infarction</u>			
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/12</u> , 19 <u>47</u> to <u>1/1</u> , 19 <u>56</u> that I last saw the deceased alive on <u>12/31</u> , 19 <u>55</u> and that death occurred at <u>6:25 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Dean H. Harding</u>		DATE SIGNED <u>Jan. 1, 1956</u>	
M. D. <u>113 Carroll St NW Wash DC</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>JAN. 3, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		LOCATION (City, town, county) (State) <u>Penn Ave Extended Pr Geo Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 1-1956</u>		REGISTRAR'S SIGNATURE <u>J. Nelson Dede</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St NW DC</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **00827**
 No. **216**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda	LENGTH OF STAY (in this place) 4 years	CITY (If outside corporate limits write RURAL and give nearest town) Bethesda	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9207 Bulls Run Parkway		STREET ADDRESS (If rural, give location) 9207 Bulls Run Parkway	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) Robert	(Middle) R.	(Last) Redfield	(Month) January (Day) 2 (Year) 19 56
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: July 7, 1923
9. AGE last birthday: 32 yrs.		10. BIRTHPLACE (State or foreign country): Ogden Utah	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Physician		10b. KIND OF BUSINESS OR INDUSTRY: Medical	
11. FATHER'S NAME: Cleveland Redfield		12. MOTHER'S MAIDEN NAME: Emma Stone	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		14. SOCIAL SECURITY No.: None	
15. INFORMANT & ADDRESS: Elizabeth G. Redfield- Same Item #2			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) Respiratory Depression and Failure	DUE TO	8 hr
Antecedent cause(s) (b) Ingestion of Depressant Drugs-	DUE TO	12 hr.
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION: 2	19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Jan. 2, 1956 4 P.M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Type not yet determined

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE **John S. Ball** CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **2 Jan 1956**
 DEPUTY MEDICAL EXAMINER ☐ M. D. ASSISTANT MEDICAL EXAM. **2 Jan 1956**

23. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit	DATE THEREOF: 1/3/56	NAME OF CEMETERY OR CREMATORY: Ogden	LOCATION (City, town, or county) (State): Weber Co. Utah
DATE REC'D BY LOCAL REG. 1/4/56	REGISTRAR'S SIGNATURE: Bessie M. Thompson	24. FUNERAL DIRECTOR: Robert A. Humphrey	ADDRESS: Bethesda, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 9 1952

RECEIVED

854

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <i>Kensington Md.</i>				STREET ADDRESS (If rural give location)		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		3104 Jennings Road		3104 Jennings Road		1	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <i>Mary A. Reed</i>				DATE OF DEATH: <i>Jan 11 1956</i>			
5. SEX: <i>F</i>		6. COLOR OR RACE: <i>M</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>June 16, 1884</i>	
9. AGE last birthday <i>71</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>own home</i>		11. BIRTHPLACE (State or foreign country): <i>Austria</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>unknown</i>				14. MOTHER'S MAIDEN NAME: <i>unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS: <i>Mr. Paul M. Reed, 3104 Jennings Road Kensington, Maryland</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A)		CORONARY Occlusion		INTERVAL BETWEEN ONSET AND DEATH	
420.1		DUE TO				8 hours	
ANTECEDENT CAUSE (S)		(B)		A ATERIO Sclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 10</i> , 1956, to <i>Jan 11</i> , 1956, that I last saw the deceased alive on <i>Jan 10</i> , 1956, and that death occurred at <i>6:00 AM</i> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<i>Michael R. Dolbrige</i>		<i>12101 Bushey Dr. Silver Spring, Md.</i>		<i>Jan 11, 1956</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1/13/56		Arlington National Cemetery		Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
1-13-56		<i>Frances Potter</i>		<i>Warner E. Humphrey</i>		8434 Ga. Ave. Silver Spring, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Jan 11, 1956 -

Coroner notified: No autopsy to be performed.

in chief as a

BUREAU V. S.

JAN 17 1956

RECEIVED

855

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda</u>		<u>58</u> days		OR TOWN <u>Norfolk</u> <u>83X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>52 The Clinical Center Bethesda, Maryland</u>				<u>879 Washington Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Emma -- Reid</u>				<u>Jan. 3, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F.</u>	<u>Negro</u>	<u>Married</u>	<u>June 5, 1919</u>	<u>36</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>		<u>Domestic</u>		<u>North Carolina</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Jack Morrison</u>				<u>Mary Bloom</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>Not available</u>		<u>The Medical Record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Jejunal obstruction</u>						<u>9 days</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Peritoneal adhesions</u>						<u>2 wks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Carcinoma of cervix & metastases</u>						<u>2 1/2 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>3 12/10/55</u>				<u>Metastatic tumor liver. Celostomy performed</u>			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 6 1955</u> , to <u>Jan. 3, 1956</u> that I last saw the deceased alive on <u>Jan. 3, 1956</u> , and that death occurred at <u>10:45 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Arthur George Ship</u> M. D.				DATE SIGNED <u>1/5/56</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>1-6-56</u>				<u>Hamlet</u>		<u>N. C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1/4/56</u>		<u>Bessie M. Thompson</u>		<u>FRAZIER'S FUNERAL HOME</u>		<u>389 P. I.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 9 1934

BUREAU V. S.

856

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

COUNTY **Montgomery** MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) **Bethesda Rural**
 TOWN **Bethesda Rural** LENGTH OF STAY (in this place) **4 days**

HOSPITAL OR INSTITUTION OR STREET ADDRESS **U. S. Naval Hospital**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **P. Kent**
 CITY (If outside corporate limits, write RURAL and give nearest town) **Cheverly**
 TOWN **Cheverly** 16-38-2

STREET ADDRESS (If rural give location) **6103 Kilmer Street**

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Jennie**Stephanie****RHODES**

(Type or Print)

4. DATE (Month) (Day) (Year)

OF DEATH:

January 13**1956**

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) **Widowed**

8. DATE OF BIRTH:

3-15-86

9. AGE last birthday

69 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **Housewife**

10B. KIND OF BUSINESS OR INDUSTRY: **Housewife**

11. BIRTHPLACE (State or foreign country): **Michigan**

12. CITIZEN OF WHAT COUNTRY? **US**

13. FATHER'S NAME:

Frederick WILDMAN

14. MOTHER'S MAIDEN NAME:

Margaret WILSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) **No**

16. SOCIAL SECURITY No.

None

17. INFORMANT'S ADDRESS: **Son William J. RHODES Same as above**

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

Cerebral Thrombosis

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

6 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. **Rheumatic Heart Disease**

20. AUTOPSY? YES ☒ NO ☐

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **9 Jan**, 19**56**, to **13 Jan**, 19**56**, that I last saw the deceased

alive on **13 Jan**, 19**56**, and that death occurred at **1:15 A**, from the causes and on the date stated above.

SIGNATURE **A. J. Capelle**

ADDRESS

DATE SIGNED

A. J. CAPELLE LCDR, MC, USN U. S. Naval Hospital, NMMC, Bethesda, Maryland

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial**16 Jan 1956****Arlington National Cemetery****Arlington, Virginia**

DATE REC'D BY LOCAL REGISTRAR

13 Jan 1956

REGISTRAR'S SIGNATURE

Mary E. Casella

24. FUNERAL HOME

ADDRESS

3831 Georgia Avenue, N.W. Wash D.C.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 16 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Dist. Col.</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockville</u>		LENGTH OF STAY (in this place) <u>4 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u>		<u>47x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8 Manakee Street</u>				STREET ADDRESS (If rural, give location) <u>4442 Mass. Ave. N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Mary Elizabeth RICKETTS</u>				4. DATE OF DEATH: January 11 19 56			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Aug. 27, 1873</u>	9. AGE last birthday: <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Housework</u>		11. BIRTHPLACE (State or foreign country): <u>Rockville Maryland</u>	
13. FATHER'S NAME: <u>James F. Gettings</u>				14. MOTHER'S MAIDEN NAME: <u>Frances Bean</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Florence Lovie Ricketts</u> <u>10420 Haywood Dr. Silver spring, Md.</u>	

18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral hemorrhage</u>		<u>4 days</u>
Antecedent cause(s) (b) <u>Hypertensive heart disease</u>		<u>4-5 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Generalized arteriosclerosis</u>		<u>20 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/7</u> , 19 <u>55</u> , to <u>1/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>1/10</u> , 19 <u>55</u> , and that death occurred at <u>6:30 p.m.</u> , from the causes and on the date stated above.					
SIGNATURE <u>M. G. Hall</u>		(DEGREE OR TITLE) <u>M.D.</u>		ADDRESS <u>Rockville, Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>1-15-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
DATE REC'D BY LOCAL REG. <u>1/13/56</u>	REGISTRAR'S SIGNATURE <u>Laurel St. Bagby</u>	24. FUNERAL DIRECTOR <u>Robert D. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 16 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00832

223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Takoma Park</u>		<u>18 days</u>		TOWN <u>Takoma Park</u>		<u>17</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium and Hospital</u>				STREET ADDRESS (If rural give location) <u>8113 Carroll Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Florence Isabel Robeson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan 6 1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Cauc.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>9-14-1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Govt Clerk</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Dist. of Columbia</u>	
13. FATHER'S NAME: <u>John Glick</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Wambold</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Embolic, cerebral artery</u>		<u>17 days</u>
DUE TO (B) <u>Myocardial infarction, left ventricle of heart</u>		<u>several months</u>
DUE TO (C) <u>Healing infarct of myocardium, apex left ventricle</u>		<u>18 months</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
----------------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, etc.) OF INJURY <u>street, office bldg., etc.</u>	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>1200 Leabon Street Silver Spring Maryland</u>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December 20, 1955, to January 6, 1956, that I last saw the deceased alive on January 6, 1956, and that death occurred at 12 P. M., from the causes and on the date stated above.

SIGNATURE <u>Robbin M. D.</u>	ADDRESS <u>1200 Leabon Street Silver Spring Maryland</u>	DATE SIGNED <u>Jan 6, 1956</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Jan 9-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>
DATE REC'D BY LOCAL REGISTRAR <u>Jan 6-1956</u>	REGISTRAR'S SIGNATURE <u>John D. Doherty</u>	24. FUNERAL DIRECTOR <u>The S.H. Hines Co</u>
		ADDRESS <u>2901-14th St. N.W. D.C.</u>

BUREAU V. S.

JAN 10 1936

RECEIVED

857

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR TOWN <u>Bethesda</u>)		LENGTH OF STAY (in this place) <u>45 hours</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>2407 Lindell Street</u>			
3. NAME OF DECEASED: (First) <u>Louise</u> (Middle) <u>Ellen</u> (Last) <u>Robinson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1 - 7 1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>8/25/88</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salisbury</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>retired</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William F. Fowler</u>				14. MOTHER'S MAIDEN NAME:			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Charles C Robinson 317 Woodburn Rd. Rockville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
260X							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 1, 1955</u> , to <u>Jan. 7, 1956</u> , that I last saw the deceased alive on <u>Jan. 6, 1956</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Walter K Angerine</u>		<u>M.D. 6300-13th St. NW Wash. D.C.</u>		<u>Jan. 7, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-1-56</u>		<u>Landon Park Cem.</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1/9/56</u>		<u>Bessie M. Thompson</u>		<u>J. Arthur Walters</u>		<u>254 Carroll St. N.E.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JAN 11 1956

RECEIVED

858 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bethesda</u>		<u>2 1/2</u> yrs.		TOWN <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4620 Drummond Ave.</u>				STREET ADDRESS (If rural give location) <u>4620 Drummond Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Clarence P. Rowland</u>				OF DEATH: <u>Jan. 20, 19 56</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Oct. 16, 1882</u>	<u>73</u> yrs.	<u>3</u> Months	<u>4</u> Days	<u></u> Hours <u></u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Bank Officer</u>		<u>Retired</u>		<u>Penna.</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John S. Rowland</u>				<u>Annie E. Pidgeon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>180-12-0116</u>		<u>William F. Rowland</u> <u>4620 Drummond Ave, Bethesda, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>		<u>10 15 min.</u>
DUE TO		
ANTECEDENT CAUSE (S) (B) <u>GENERALIZED ARTERIO SCLEROSIS</u>		<u>10 yrs</u>
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 JUNE, 1955, to 20 JAN., 1956, that I last saw the deceased alive on 12 JANUARY, 1956, and that death occurred at 6:30 PM, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial-Transit</u>	<u>1-24-56</u>	<u>Fernwood Cemetery</u>	<u>Delaware Co. Pa.</u>

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-31-56Bessie M. ThompsonRobert A. PumphreyBethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 3 1956

BUREAU V. S.

859 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
<u>Olney</u>		<u>3 mos. 3 wks</u>		<u>Laytonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>The Montgomery County General Hospital, Inc.</u>				<u>/</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)			
<u>Willis</u>		<u>Burnside</u>		<u>Runkles</u>			
(Type or Print)							
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>male</u>		<u>white</u>		<u>widowed</u>		<u>10/26/64</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>91</u> yrs.		Months		Days		Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
<u>none</u>				<u>none</u>			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>Maryland</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Baisl Runkles</u>				<u>Mary Ellen Mentzer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):				16. SOCIAL SECURITY NO.			
<u>no</u>				<u>none</u>			
17. INFORMANT & ADDRESS:							
<u>Hospital Records</u>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Senility</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov.</u> , 19 <u>55</u> , to <u>Jan. 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 1</u> , 19 <u>56</u> , and that death occurred at <u>2:26 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank Schumacher</u>				DATE SIGNED <u>Jan. 9, 56</u>			
M. D. <u>Southsburg, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 4, 1956</u>		<u>Prospect</u>		<u>Fredricks Co Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-4-56</u>		<u>Bertrude B Lawler</u>		<u>Roy W Barber</u>		<u>Laytonville Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 9 1956

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

860

CERTIFICATE OF DEATH

00836

Reg. Dist. No. 212

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Montgomery</i>		STATE <i>Maryland</i>		COUNTY <i>Montgomery</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <i>Boyd's - RFD</i>		<i>30 yrs</i>		OR TOWN <i>Boyd's - RFD</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Harry Randolph Savage</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Jan-22 1956</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Feb-22-1879</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Former (Owner)</i>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <i>76 yrs.</i>		IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>				12. CITIZEN OF WHAT COUNTRY? <i>US</i>			
13. FATHER'S NAME <i>George D Savage</i>				14. MOTHER'S MAIDEN NAME <i>Martha E. Ballenger</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>Leroy Savage - Boyd's, Md</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>						INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Cerebral arteriosclerosis</i>						<i>2 years</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 1</i> , 19 <i>56</i> , to <i>Jan 22</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Jan 22</i> , 19 <i>56</i> , and that death occurred at <i>3:00 P.</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Vernon E. Masters</i>				ADDRESS (Street, city, town, state) <i>German Town, Md</i>			
DATE SIGNED <i>Jan 22, 56</i>				DATE SIGNED <i>Jan 22, 56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1/25/56</i>		NAME OF CEMETERY OR CREMATORY <i>Monocacy</i>		LOCATION (City, town, or county) (State) <i>Beallsville, Md</i>	
24. REC'D BY REGISTRAR <i>Jan 23/56</i>		REGISTRAR'S SIGNATURE <i>Charles E. Egan</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William B. Hilton</i>		ADDRESS <i>Barnesville, Md</i>	

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10

U. S. BUREAU

RECEIVED

732

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Takoma Park</u>		<u>3 days</u>		TOWN <u>Rockville</u>		<u>26</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Washington Sanitarium + Hospital 5821 Crawford Drive</u>				<u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Gertrude Dale Schroeder</u>				DEATH: <u>January 19 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>Sept 26, 1913</u>	
9. AGE last birthday <u>42</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Hswt</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>William D. Dale</u>				14. MOTHER'S MAIDEN NAME: <u>Lillian McCurdy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If yes give war or dates of service): <u>No</u>				15. SOCIAL SECURITY NO.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Mr. Louis W. Schroeder - same address.</u>	

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
581.1 IMMEDIATE CAUSE (A) <u>Lower nephron nephrosis</u>		<u>3 days</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Acute Alcoholism</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 322.0 DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Loose, Curious</u>		

19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 16, 1956</u> , to <u>Jan 19, 1956</u> , that I last saw the deceased alive on <u>Jan 19, 1956</u> , and that death occurred at <u>P</u> M, from the causes and on the date stated above.					
SIGNATURE <u>Raymond O. Oest</u> M.D.		ADDRESS <u>Takoma Park, Md.</u> DATE SIGNED <u>Jan 20/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>1/24/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
LOCATION (City, town, or county) (State) <u>Switzland Md.</u>		DATE REC'D BY LOCAL REGISTRAR <u>Jan 21/56</u>		REGISTRAR'S SIGNATURE <u>William Dodd</u>	
24. FUNERAL DIRECTOR <u>W. W. Chambers</u>		ADDRESS <u>3072 N. St. N.W. Wash. D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 24 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: 861		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Mont.
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural	LENGTH OF STAY (in this place) 9 hrs 29 min	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital	STREET ADDRESS (If rural give location) 6913 Westmoreland Avenue		
3. NAME OF DECEASED: (First) Lorraine (Middle) Dawn (Last) SCHUBERT		4. DATE (Month) (Day) (Year) OF DEATH: January 8 19 56	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 1-8-56
9. AGE last birthday 9 yrs.		10. IF UNDER 1 YEAR Months 9 Days 29	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None	
11. BIRTHPLACE (State or foreign country): Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Harvey C. SCHUBERT		14. MOTHER'S MAIDEN NAME: Margaret J. MEADOWS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) - -		16. SOCIAL SECURITY NO. - -	
17. INFORMANT & ADDRESS: Father Harvey C. SCHUBERT Same as above			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 762.0 Congenital Atelectasis			9 1/2 hrs.
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8 Jan , 19 56 , to 8 Jan , 19 56 , that I last saw the deceased alive on 8 Jan , 19 56 , and that death occurred at 9:30P M, from the causes and on the date stated above.			
SIGNATURE George J.A. Magnant		DATE SIGNED	
G. J.A. MAGNANT LT, MC, USN U. S. Naval Hospital, NMMC, Bethesda, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 13 Jan 1956	
NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 9 Jan 1956		REGISTRAR'S SIGNATURE Mary E. Craselly	
24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home		ADDRESS 7557 Wisconsin Avenue, Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 11 1956

RECEIVED

862
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Chevy Chase</u>				OR TOWN <u>Chevy Chase</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5300 Saratoga Ave</u>				STREET ADDRESS (If rural give location) <u>5300 Saratoga Avenue</u>			
3. NAME OF DECEASED: (Type or Print) <u>Leon Perry Shoemaker</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>January 3 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>10-8-1891</u>	
				9. AGE last birthday: <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. <u>2</u> Months <u>25</u> Days <u></u> Hours <u></u> Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Ret. Civil Eng.</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Self-emp.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>William Shoemaker</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Eliza Perry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY NO.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Rudolph J. Bopp</u> <u>5300 Saratoga Ave. Ch. Ch. Md.</u>	

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<u>420.1</u> Immediate cause (a) <u>Gastric hemorrhages</u>				<u>24 hours</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Congestive heart failure</u>				<u>2 days</u>	
(c) <u>Coronary artery disease</u>				<u>6 weeks</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12-29-1955</u> to <u>Jan 3 1956</u> , that I last saw the deceased alive on <u>Jan 3 1956</u> , and that death occurred at <u>9:45 AM</u> from the causes and on the date stated above.					
SIGNATURE <u>Roger Kutz</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>3701 Connecticut Ave. NW. Jan 3 1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>1-6-1956</u>		<u>Parklawn</u>	
LOCATION (City, town, or county) (State)		DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>Rockville Md.</u>		<u>1/4/56</u>		<u>Bennie M. Thompson</u>	
ADDRESS		24. FUNERAL DIRECTOR		<u>Robert A. Humphrey</u>	
<u>Bethesda, Md.</u>					

MARGIN RESERVED FOR BRIDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 9 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

863

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 00840

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Silver Springs</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Silver Springs</u>		56	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2223 Osborn Drive</u>				STREET ADDRESS (If rural, give location) <u>2223 Osborn Drive</u>			
3. NAME OF DECEASED: (Type or Print) <u>Jacob</u>		(First) (Middle) (Last) <u>Silverman</u>		4. DATE OF DEATH <u>Jan 7</u>		19 <u>56</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W-</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>	8. DATE OF BIRTH:	9. AGE last birthday: <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Ready to wear</u>		11. BIRTHPLACE (State or foreign country): <u>Lith</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Simon</u>				14. MOTHER'S MAIDEN NAME: <u>Rachael</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Marvin Conn - Same</u>			

18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks</u> <u>Six Months</u>
Immediate cause (a) <u>Starvation</u> DUE TO Antecedent cause(s) (b) <u>Carcinoma of Stomach</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>9 Nov. 1955</u>		19b. MAJOR FINDING OF OPERATION: <u>Carcinoma of Stomach</u>			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>John S. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Jan 1956</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>1-11-56</u>		NAME OF CEMETERY OR CREMATORY: <u>Ferryman Run</u>	
DATE REC'D BY LOCAL REG: <u>1/14/56</u>		REGISTRAR'S SIGNATURE: <u>C. W. Hedrick</u>		24. FUNERAL DIRECTOR: <u>Jack Lewis Inc</u>	
				LOCATION (City, town, or county) (State): <u>Balto Md</u>	
				ADDRESS: <u>2100 Eutaw Pl</u>	

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY
OFFICE OF THE CHIEF OF THE BUREAU OF THE ARMY
WASHINGTON, D. C.

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY
OFFICE OF THE CHIEF OF THE BUREAU OF THE ARMY
WASHINGTON, D. C.

1. The first part of the report is a general statement of the work done during the year. It is a summary of the work done by the Bureau of the Army, and is intended to give a general idea of the work done by the Bureau of the Army.

2. The second part of the report is a statement of the work done by the Bureau of the Army during the year. It is a summary of the work done by the Bureau of the Army, and is intended to give a general idea of the work done by the Bureau of the Army.

3. The third part of the report is a statement of the work done by the Bureau of the Army during the year. It is a summary of the work done by the Bureau of the Army, and is intended to give a general idea of the work done by the Bureau of the Army.

4. The fourth part of the report is a statement of the work done by the Bureau of the Army during the year. It is a summary of the work done by the Bureau of the Army, and is intended to give a general idea of the work done by the Bureau of the Army.

5. The fifth part of the report is a statement of the work done by the Bureau of the Army during the year. It is a summary of the work done by the Bureau of the Army, and is intended to give a general idea of the work done by the Bureau of the Army.

6. The sixth part of the report is a statement of the work done by the Bureau of the Army during the year. It is a summary of the work done by the Bureau of the Army, and is intended to give a general idea of the work done by the Bureau of the Army.

7. The seventh part of the report is a statement of the work done by the Bureau of the Army during the year. It is a summary of the work done by the Bureau of the Army, and is intended to give a general idea of the work done by the Bureau of the Army.

8. The eighth part of the report is a statement of the work done by the Bureau of the Army during the year. It is a summary of the work done by the Bureau of the Army, and is intended to give a general idea of the work done by the Bureau of the Army.

9. The ninth part of the report is a statement of the work done by the Bureau of the Army during the year. It is a summary of the work done by the Bureau of the Army, and is intended to give a general idea of the work done by the Bureau of the Army.

10. The tenth part of the report is a statement of the work done by the Bureau of the Army during the year. It is a summary of the work done by the Bureau of the Army, and is intended to give a general idea of the work done by the Bureau of the Army.

864

00841

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 214

1. PLACE OF DEATH:

COUNTY — Montgomery

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)LENGTH OF STAY
(In this place)TOWN Silver SpringHOSPITAL OR
INSTITUTION OR
STREET ADDRESS2208 Quinton Road

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery

CITY (If outside corporate limits write RURAL and give nearest town)

OR TOWN Silver Spring

STREET ADDRESS (If rural—give location)

2208 Quinton Road3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

ARNOTCRAWFORDSINE4. DATE
OF
DEATH

(Month)

(Day)

(Year)

Jan. 119 56

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) Married

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

maleWhite3/23/1441

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired): Officer - U. S. Army10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Hutchisin, Kansas12. CITIZEN OF WHAT
COUNTRY?U.S.A.

13. FATHER'S NAME:

James S. Sine

14. MOTHER'S MAIDEN NAME:

Margaret Buchan15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)yes

16. SOCIAL SECURITY No.:

no

17. INFORMANT & ADDRESS:

Mrs. Rosa B. Sine, 2208 Quinton RoadRosemary Hills, Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,

(b)

giving rise to the above cause

DUE TO

stating underlying cause last

(c)

INTERVAL BETWEEN
ONSET AND DEATH5 min.II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY Home

21c. (City or town)

(County)

(State)

Silver Spring Montgomery Md.21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY21e. INJURY OCCURRED
While at Not while
work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

Hanging22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John W. Ball

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

M. D.

ASSISTANT MEDICAL EXAM.

DATE SIGNED

19 Jan 195623. BURIAL, CREMATION,
REMOVAL (Specify):Burial

DATE THEREOF

1/5/56

NAME OF CEMETERY OR CREMATORY

Arlington Nat'l. Cemetery

LOCATION (City, town, or county)

Arlington, Virginia

(State)

DATE REC'D BY LOCAL
REG.Jan 3 1956

REGISTRAR'S SIGNATURE

Frances R. Ball

24. FUNERAL DIRECTOR

Wm. B. Humphrey

8434 Ga. Ave.

Silver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item or information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00842

865

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>One day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Maryland</u>				STREET ADDRESS (If rural give location) <u>3004 Oak Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Evangeline M. Smith</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 30, 19 56</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>15 Dec. 1907</u>	
				9. AGE last birthday <u>48</u> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Eugene Paravano</u>				14. MOTHER'S MAIDEN NAME: <u>Pauline Johnstone</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>Not available</u>		17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary infarction (multiple)</u>							
ANTECEDENT CAUSE (S) (B) <u>Metastatic Adenocarcinoma of lung</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 30, 1956</u> , to <u>Jan. 30, 19 56</u> that I last saw the deceased alive on <u>Jan. 30, 1956</u> , and that death occurred at <u>7:50P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Ross M. Miller, Jr.</u>				ADDRESS <u>M. D. The Clinical Center, NIH, Bethesda, Md.</u>		DATE SIGNED <u>1-31-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>Feb. 2, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/1/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St NE</u>	

BUREAU V. M.

FEB 3 1956

RECEIVED

866

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write and give nearest town) <u>Bethesda</u>	RURAL LENGTH OF STAY (in this place) <u>D.O.A.</u>	CITY (If outside corporate limits, write and give nearest town) <u>Bethesda</u>	RURAL <u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural give location) <u>5202 Glenwood Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>George Oscar Smithson</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 18 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify) <u>Widower</u>	8. DATE OF BIRTH: <u>3-3-94</u>
9. AGE last birthday: <u>61</u> yrs.		IF UNDER 1 YEAR: <u>10</u> Months <u>15</u> Days	IF UNDER 24 HRS. <u>15</u> Hours <u>15</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Real Estate Self-emp.</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>
13. FATHER'S NAME: <u>George W.</u>		14. MOTHER'S MAIDEN NAME: <u>Josephine LaFontaine</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>578-01-22621</u>	
17. INFORMANT'S ADDRESS: <u>Frederick Smithson - Son 3643 Van Ness ST N.W. Wash. D.C.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>47</u> to <u>Jan. 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 18</u> , 19 <u>56</u> , and that death occurred at <u>2017</u> M, from the causes and on the date stated above.			
SIGNATURE <u>W. D. Gray</u>		DATE SIGNED <u>1-18-56</u>	
M. D. <u>Bethesda, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-23-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem</u>		LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/20/56</u>		REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert A. Rumphrey</u>		ADDRESS <u>Bethesda</u>	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 24 1956

RECEIVED

00844

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 214

I. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Silver Spring LENGTH OF STAY (in this place) 2 yrs
 TOWN Silver Spring
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 1580 East West Highway

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE md COUNTY Montg
 CITY (If outside corporate limits write RURAL and give nearest town) Silver Spring
 TOWN Silver Spring
 STREET ADDRESS (If rural, give location) 1580 East West Highway

3. NAME OF DECEASED:

(First) John (Middle) Harper (Last) Snapp
 (Type or Print)

4. DATE OF DEATH (Month) (Day) (Year)
Jan 31 1956

5. SEX:

Male

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

married

8. DATE OF BIRTH:

12-11-1891

9. AGE last birthday:

64 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.
0 0 0 0

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

Photographer

10b. KIND OF BUSINESS OR INDUSTRY:

U.S. Dept of Int.

11. BIRTHPLACE (State or foreign country):

Wash. DC.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

John H. Snapp

14. MOTHER'S MAIDEN NAME:

Katharine Keys

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Mr John H. Snapp - Same as John 1

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

Sudden

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Frank J. Broschart

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

M. D.

ASSISTANT MEDICAL EXAM.

DATE SIGNED

1-31-56

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE REC'D BY LOCAL REG. 1-31-56

DATE THEREOF

2-2-56

NAME OF CEMETERY OR CREMATORY

GLEN WOOD CEMETERY

LOCATION (City, town, or county)

WASHINGTON, D.C.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Frances Teller of H. H. H. Co. Washington D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 2 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

868

CERTIFICATE OF DEATH

Reg. Dist. No. 215

00845

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE D.C.	COUNTY D.C.
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural	LENGTH OF STAY (in this place) 2 mos; 26 dys	CITY (If outside corporate limits, write RURAL and give nearest town) District of Columbia	
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, Bethesda	STREET ADDRESS (If rural give location) 3000 39th Street, NW		
3. NAME OF DECEASED: (First) (Middle) (Last) Charles Dixon SNIFFIN		4. DATE (Month) (Day) (Year) OF DEATH: January 17, 1956	
5. SEX: Male	6. COLOR OR RACE: Caucasian	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: 29 December 1887
9. AGE last birthday 68 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner		10B. KIND OF BUSINESS OR INDUSTRY: Mariner	
11. BIRTHPLACE (State or foreign country): Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Joseph SNIFFIN		14. MOTHER'S MAIDEN NAME: Elsie DULIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) WWI		16. SOCIAL SECURITY NO. 410-58-6305	
17. INFORMANT & ADDRESS: Sister: Mrs. T.B. SHOE-MAKER, 3000 39th Street, NW, Washington, D.C.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Carcinoma, Bronchogenic			
ANTECEDENT CAUSE (S) DUE TO (B) Undifferentiated with			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) extensive metastasis			7 mos
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-21- 19 55 , to 1-17- 19 56 , that I last saw the deceased alive on 1-17- 19 56 , and that death occurred at 4:50a M, from the causes and on the date stated above.			
SIGNATURE LCDR J.W. FLYNN, MC USN, USNH, NNMC, Bethesda, Md.		DATE SIGNED 18 January 1956	
23. BURIAL CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-19-56	
NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 1-18-56		24. FUNERAL DIRECTOR ADDRESS S.H. HINES, 2901 14th Street, NW, Wash., D.C.	

BUREAU V. S.

JAN 24 1956

RECEIVED

BUREAU V. S.

JAN 17 1956

RECEIVED

869

CERTIFICATE OF DEATH

Reg. Dist. No. 214...

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>D. C.</i>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>56 Silver Spring Md</i>		LENGTH OF STAY (in this place) <i>2 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Washington</i> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>9823 Deville St. House</i>				STREET ADDRESS (If rural give location) <i>1124 Kalumia Rd. N.W.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>William Watson Stivers</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>Jan 27 1956</i>			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Oct 4 - 1865</i>	9. AGE last birthday <i>90</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <i>Hotel</i>		11. BIRTHPLACE (State or foreign country): <i>Bedford, Penna</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>David Stivers</i>				14. MOTHER'S MAIDEN NAME: <i>Mary Shortzer</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service: <i>No</i>		16. SOCIAL SECURITY NO. <i>577-30-0355AX</i>		17. INFORMANT & ADDRESS:			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Acute Cardiac Failure</i>						<i>2 weeks</i>	
ANTECEDENT CAUSE (S) (B) <i>Arteriosclerotic Heart Disease</i>						<i>25 years</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 1, 1947</i> to <i>Jan 27, 1956</i> that I last saw the deceased alive on <i>1/27/56</i> , 19 <i>56</i> , and that death occurred at <i>8:10 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>John E. Everett</i>		M.D. <i>1301-14th St. Wash, D.C.</i>		DATE SIGNED <i>1/27/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-30-56</i>		NAME OF CEMETERY OR CREMATORY <i>Union Cem.</i>		LOCATION (City, town, or county) (State) <i>Meyersdale, Pa.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>1-31-56</i>		REGISTRAR'S SIGNATURE <i>Frances Teller</i>		24. FUNERAL DIRECTOR <i>H.P. Kondow</i>		ADDRESS <i>Meyersdale, Pa.</i>	

MARGIN RESERVED FOR BINDING

RECEIVED

FEB 2 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				00848 Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>	
X TOWN <u>Rural-Bethesda</u>				STREET ADDRESS (If rural, give location) <u>2300 Conn. Ave., N.W.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS					
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
<u>CAROLYN VanDOLAH TALLEY</u>			<u>Jan 4th 19 56</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: yrs. Months Days	IF UNDER 24 HRS. IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Sep. 3, 1914</u>	<u>41</u>	<u>4</u> <u>7</u> <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Ill.</u>	
13. FATHER'S NAME: <u>Louis S. VanDolah</u>		14. MOTHER'S MAIDEN NAME: <u>Blanch Stool</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>yes</u>		17. INFORMANT & ADDRESS: <u>Grant S. Talley- Item # 2</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute Barbitol Poisoning</u>					<u>?</u>
DUE TO					
Antecedent cause(s) (b) <u>ingestion of Sodium Seconal</u>					<u>?</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
DUE TO					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>John S. Ball</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4 Jan 56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Cremation</u>		DATE THEREOF <u>1-6-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>		24. FUNERAL DIRECTOR <u>Robert A. Campbell</u>		ADDRESS <u>Bethesda, Md.</u>	
DATE REC'D BY LOCAL REG. <u>1/9/56</u>		REGISTRAR'S SIGNATURE <u>Debra M. Thompson</u>			

RECEIVED

JAN 11 1956

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00849

871

CERTIFICATE OF DEATH

Reg. Dist. No. 216

Item 1. Film G192 2-6-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Manor Rural</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Washington, D. C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5712 Mass. Avenue</u>				STREET ADDRESS <u>5712 Mass. Ave. N. W.</u>			
3. NAME OF DECEASED (Type or Print) <u>Charlotte Carr Taylor</u>				4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 21, 1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Edward T. Carr.</u>				14. MOTHER'S MAIDEN NAME <u>Emma Bollinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yas, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mavis T. Overstreet</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u>						<u>4 DAYS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY</u>						<u>6 1/2 YEARS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CEREBRAL</u>						<u>6 1/2 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCT</u> , 19 <u>55</u> , to <u>1/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/26</u> , 19 <u>56</u> , and that death occurred at <u>2:40</u> PM, from the causes and on the date stated above. SIGNATURE <u>M. T. Overstreet</u> M.D. <u>11-1016-16</u> ST. N.W. D.C. <u>1/24/56</u> ADDRESS (Street, city, town, state) <u>ROANOKE, VA.</u> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		DATE THEREOF <u>1/28/55</u>		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State) <u>ROANOKE, VA.</u>	
24. REC'D BY REGISTRAR <u>1-30-56</u>		REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson</u>		ADDRESS <u>Co. 1300 N. S. E. N. W.</u>	

9. *Chrysomelidae*

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BUREAU V. S.

FEB 2 1956

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CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>
OR and give nearest town <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>16 days</u>	OR TOWN <u>Bethesda</u>	STREET ADDRESS (If rural give location) <u>4705 Highland Ave.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>			
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>William</u> (Middle) <u>Dudley</u> (Last) <u>Terry</u>	(Type or Print)	Month <u>Jan</u> (Day) <u>25</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 6, 1889</u>
9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Instrument Maker</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): <u>Mohawk New York</u>
13. FATHER'S NAME: <u>Jerome Terry</u>		14. MOTHER'S MAIDEN NAME: <u>Roudine, Jenny</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>214-18-8028</u>	
17. INFORMANT & ADDRESS: <u>Wife, Mildred Terry - above</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Pneumonia, bronch</u>			<u>Few days</u>
ANTECEDENT CAUSE (B) <u>Coronary insufficiency</u>			<u>2 weeks</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Coronary Arteriosclerosis</u>			<u>2 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Carcinoma Rectum</u>			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec</u> , 19 <u>55</u> , to <u>Jan 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>56</u> , and that death occurred at <u>3:20 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. D. D. Brown</u>		DATE SIGNED <u>1/25/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-27-1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-31-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Bethesda, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 3 1956

BUREAU V. S.

873

CERTIFICATE OF DEATH

Reg. Dist. No. 216...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cherry Chase</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cherry Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6716 Fairfax Rd</u>				STREET ADDRESS (If rural give location) <u>6716 Fairfax Rd.</u>			
3. NAME OF DECEASED: (First) <u>Olin</u> (Middle) <u>B.</u> (Last) <u>Tharp</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 26</u> 19 <u>56</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED, DIVORCED. <u>married</u>	8. DATE OF BIRTH: <u>4-19-1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired): <u>Western Elec. Co. Telephone Equipment</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>West Va</u>		11. BIRTHPLACE (State or foreign country): <u>U. S.</u>	
13. FATHER'S NAME: <u>John L Tharp</u>				14. MOTHER'S MAIDEN NAME: <u>Bosley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY No. <u>577-09-9820</u>		17. INFORMANT & ADDRESS: <u>Mrs G. Tharp 6716 Fairfax Rd. Ch. Ch. Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>PULMONARY INFARCTION</u>						<u>5 minutes</u>	
ANTECEDENT CAUSE (S) (B) <u>MYOCARDIAL INFARCTION</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>HYPERTENSION</u>						<u>6 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 24</u> , 19 <u>56</u> , to <u>Jan. 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 24</u> , 19 <u>56</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter B. Credit</u>		ADDRESS <u>M. D. Washington Clinic</u>		DATE SIGNED <u>1/26/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-30-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem</u>		LOCATION (City, town, or county) (State) <u>P. Geo. County</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-26-56</u>		REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>		24. FUNERAL DIRECTOR <u>St. Hones Co</u>		ADDRESS <u>2901-14th St. N.W. Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 30 1956

RECEIVED

734

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Takoma Park</i>	LENGTH OF STAY (in this place) <i>39 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington Sanitarium Hospital</i>		STREET ADDRESS (If rural give location) <i>3509 Woodbine St</i>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print) <i>Lea</i>	(First) <i>Lea</i>	(Middle) <i>Marie</i>	(Last) <i>Tolstoi</i>
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>12-23-1900</i>
9. AGE last birthday <i>55</i> yrs.		10. AGE last birthday <i>55</i> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Penna</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Bernard Matthews</i>		14. MOTHER'S MAIDEN NAME: <i>Rose Kessloff</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <i>Washington Sanitarium Hospital Records</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE		
(A) <i>Recurrent adenocarcinoma sigmoid with metastasis</i>		<i>18 mo.</i>
ANTECEDENT CAUSE (S)		
(B) <i>adenocarcinoma ascending colon</i>		<i>5 1/2 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
--	--

19A. DATE OF OPERATION: <i>3.9.55</i>	19B. MAJOR FINDINGS OF OPERATION: <i>Recurrent malignancy involving pelvic fascia in sigmoid region secondary to adenocarcinoma colon & ovaries</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <i>May</i> , 1950, to <i>1.1.56</i> , that I last saw the deceased alive on <i>12.31.55</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.	
SIGNATURE <i>Stanley Paul Olson</i>	DATE SIGNED <i>1.1.56</i>
ADDRESS <i>M. D. 300 Hamilton St. N. W.</i>	

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>Jan. 3-1956</i>	NAME OF CEMETERY OR CREMATORY <i>Brais Israel Cem</i>	LOCATION (City, town, or county) (State) <i>Oxon Hill Md</i>
DATE REC'D BY LOCAL REGISTRAR <i>Jan. 1-1956</i>	REGISTRAR'S SIGNATURE <i>J. Wilson Neeld</i>	24. FUNERAL DIRECTOR <i>Belamant & Son</i>	ADDRESS <i>Wash. D. C.</i>

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

874

CERTIFICATE OF DEATH

00853

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN SILVER SPRING		34 yrs.		TOWN SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
638 RITCHIE AVENUE				638 RITCHIE AVENUE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JOHN (Middle) A. (Last) VAN HORN				(Month) JAN. (Day) 16 (Year) 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	WIDOWED	FEB. 28, 1866	89 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
PLASTERER - RETIRED					MARYLAND		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
OLIVER VAN HORN				SALLY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		220-05-4088		Mr. Herbert Van Horn 4624 Saul Rd., Kensington, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
334X IMMEDIATE CAUSE (A) Cerebral arteriosclerosis							
ANTECEDENT CAUSE(S) DUE TO (B) Generalized arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic heart disease							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from Jan 11, 1953, to Jan 16, 1956, that I last saw the deceased alive on Jan 12, 1956, and that death occurred at 12:55 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Adrian H. Traumm M.D.				8237 George Ave Silver Spring Md 416-58			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		1/19/56		GEO. WASH. MEM. CEMETERY		PRINCE GEO. COUNTY, MARYLAND	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 1-19-56		Frances Potter		Wm. E. Pumphrey		SILVER SPRING, MD.	

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF STATE

22. SIGNATURE OF UNION

23. SIGNATURE OF COUNTRY

24. SIGNATURE OF WORLD

25. SIGNATURE OF UNIVERSE

26. SIGNATURE OF GOD

27. SIGNATURE OF DEVIL

28. SIGNATURE OF ANGELS

29. SIGNATURE OF DEMONS

30. SIGNATURE OF SPIRITS

31. SIGNATURE OF SOULS

32. SIGNATURE OF BODIES

33. SIGNATURE OF MINDS

34. SIGNATURE OF HEARTS

35. SIGNATURE OF LIVERS

36. SIGNATURE OF STOMACHS

37. SIGNATURE OF LUNGS

38. SIGNATURE OF KIDNEYS

39. SIGNATURE OF SPLEENS

40. SIGNATURE OF PANCREASES

41. SIGNATURE OF GALLBLADDERS

42. SIGNATURE OF LIVERS

43. SIGNATURE OF STOMACHS

44. SIGNATURE OF LUNGS

45. SIGNATURE OF KIDNEYS

46. SIGNATURE OF SPLEENS

47. SIGNATURE OF PANCREASES

48. SIGNATURE OF GALLBLADDERS

49. SIGNATURE OF LIVERS

50. SIGNATURE OF STOMACHS

51. SIGNATURE OF LUNGS

52. SIGNATURE OF KIDNEYS

53. SIGNATURE OF SPLEENS

54. SIGNATURE OF PANCREASES

55. SIGNATURE OF GALLBLADDERS

56. SIGNATURE OF LIVERS

57. SIGNATURE OF STOMACHS

58. SIGNATURE OF LUNGS

59. SIGNATURE OF KIDNEYS

60. SIGNATURE OF SPLEENS

61. SIGNATURE OF PANCREASES

62. SIGNATURE OF GALLBLADDERS

63. SIGNATURE OF LIVERS

64. SIGNATURE OF STOMACHS

65. SIGNATURE OF LUNGS

66. SIGNATURE OF KIDNEYS

67. SIGNATURE OF SPLEENS

68. SIGNATURE OF PANCREASES

69. SIGNATURE OF GALLBLADDERS

70. SIGNATURE OF LIVERS

71. SIGNATURE OF STOMACHS

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73. SIGNATURE OF KIDNEYS

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76. SIGNATURE OF GALLBLADDERS

77. SIGNATURE OF LIVERS

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79. SIGNATURE OF LUNGS

80. SIGNATURE OF KIDNEYS

81. SIGNATURE OF SPLEENS

82. SIGNATURE OF PANCREASES

83. SIGNATURE OF GALLBLADDERS

84. SIGNATURE OF LIVERS

85. SIGNATURE OF STOMACHS

86. SIGNATURE OF LUNGS

87. SIGNATURE OF KIDNEYS

88. SIGNATURE OF SPLEENS

89. SIGNATURE OF PANCREASES

90. SIGNATURE OF GALLBLADDERS

91. SIGNATURE OF LIVERS

92. SIGNATURE OF STOMACHS

93. SIGNATURE OF LUNGS

94. SIGNATURE OF KIDNEYS

95. SIGNATURE OF SPLEENS

96. SIGNATURE OF PANCREASES

97. SIGNATURE OF GALLBLADDERS

98. SIGNATURE OF LIVERS

99. SIGNATURE OF STOMACHS

100. SIGNATURE OF LUNGS

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102. SIGNATURE OF SPLEENS

103. SIGNATURE OF PANCREASES

104. SIGNATURE OF GALLBLADDERS

105. SIGNATURE OF LIVERS

106. SIGNATURE OF STOMACHS

107. SIGNATURE OF LUNGS

108. SIGNATURE OF KIDNEYS

109. SIGNATURE OF SPLEENS

110. SIGNATURE OF PANCREASES

111. SIGNATURE OF GALLBLADDERS

112. SIGNATURE OF LIVERS

113. SIGNATURE OF STOMACHS

114. SIGNATURE OF LUNGS

115. SIGNATURE OF KIDNEYS

116. SIGNATURE OF SPLEENS

117. SIGNATURE OF PANCREASES

118. SIGNATURE OF GALLBLADDERS

119. SIGNATURE OF LIVERS

120. SIGNATURE OF STOMACHS

121. SIGNATURE OF LUNGS

122. SIGNATURE OF KIDNEYS

123. SIGNATURE OF SPLEENS

124. SIGNATURE OF PANCREASES

125. SIGNATURE OF GALLBLADDERS

126. SIGNATURE OF LIVERS

127. SIGNATURE OF STOMACHS

128. SIGNATURE OF LUNGS

129. SIGNATURE OF KIDNEYS

130. SIGNATURE OF SPLEENS

131. SIGNATURE OF PANCREASES

132. SIGNATURE OF GALLBLADDERS

133. SIGNATURE OF LIVERS

134. SIGNATURE OF STOMACHS

135. SIGNATURE OF LUNGS

136. SIGNATURE OF KIDNEYS

137. SIGNATURE OF SPLEENS

138. SIGNATURE OF PANCREASES

139. SIGNATURE OF GALLBLADDERS

140. SIGNATURE OF LIVERS

141. SIGNATURE OF STOMACHS

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143. SIGNATURE OF KIDNEYS

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145. SIGNATURE OF PANCREASES

146. SIGNATURE OF GALLBLADDERS

147. SIGNATURE OF LIVERS

148. SIGNATURE OF STOMACHS

149. SIGNATURE OF LUNGS

150. SIGNATURE OF KIDNEYS

151. SIGNATURE OF SPLEENS

152. SIGNATURE OF PANCREASES

153. SIGNATURE OF GALLBLADDERS

154. SIGNATURE OF LIVERS

155. SIGNATURE OF STOMACHS

156. SIGNATURE OF LUNGS

157. SIGNATURE OF KIDNEYS

158. SIGNATURE OF SPLEENS

159. SIGNATURE OF PANCREASES

160. SIGNATURE OF GALLBLADDERS

161. SIGNATURE OF LIVERS

162. SIGNATURE OF STOMACHS

163. SIGNATURE OF LUNGS

164. SIGNATURE OF KIDNEYS

165. SIGNATURE OF SPLEENS

166. SIGNATURE OF PANCREASES

167. SIGNATURE OF GALLBLADDERS

168. SIGNATURE OF LIVERS

169. SIGNATURE OF STOMACHS

170. SIGNATURE OF LUNGS

171. SIGNATURE OF KIDNEYS

172. SIGNATURE OF SPLEENS

173. SIGNATURE OF PANCREASES

174. SIGNATURE OF GALLBLADDERS

175. SIGNATURE OF LIVERS

176. SIGNATURE OF STOMACHS

177. SIGNATURE OF LUNGS

178. SIGNATURE OF KIDNEYS

179. SIGNATURE OF SPLEENS

180. SIGNATURE OF PANCREASES

181. SIGNATURE OF GALLBLADDERS

182. SIGNATURE OF LIVERS

183. SIGNATURE OF STOMACHS

184. SIGNATURE OF LUNGS

185. SIGNATURE OF KIDNEYS

186. SIGNATURE OF SPLEENS

187. SIGNATURE OF PANCREASES

188. SIGNATURE OF GALLBLADDERS

189. SIGNATURE OF LIVERS

190. SIGNATURE OF STOMACHS

191. SIGNATURE OF LUNGS

192. SIGNATURE OF KIDNEYS

193. SIGNATURE OF SPLEENS

194. SIGNATURE OF PANCREASES

195. SIGNATURE OF GALLBLADDERS

196. SIGNATURE OF LIVERS

197. SIGNATURE OF STOMACHS

198. SIGNATURE OF LUNGS

199. SIGNATURE OF KIDNEYS

200. SIGNATURE OF SPLEENS

201. SIGNATURE OF PANCREASES

202. SIGNATURE OF GALLBLADDERS

203. SIGNATURE OF LIVERS

204. SIGNATURE OF STOMACHS

205. SIGNATURE OF LUNGS

206. SIGNATURE OF KIDNEYS

207. SIGNATURE OF SPLEENS

208. SIGNATURE OF PANCREASES

209. SIGNATURE OF GALLBLADDERS

210. SIGNATURE OF LIVERS

211. SIGNATURE OF STOMACHS

212. SIGNATURE OF LUNGS

213. SIGNATURE OF KIDNEYS

214. SIGNATURE OF SPLEENS

215. SIGNATURE OF PANCREASES

216. SIGNATURE OF GALLBLADDERS

217. SIGNATURE OF LIVERS

218. SIGNATURE OF STOMACHS

219. SIGNATURE OF LUNGS

220. SIGNATURE OF KIDNEYS

221. SIGNATURE OF SPLEENS

222. SIGNATURE OF PANCREASES

223. SIGNATURE OF GALLBLADDERS

224. SIGNATURE OF LIVERS

225. SIGNATURE OF STOMACHS

226. SIGNATURE OF LUNGS

227. SIGNATURE OF KIDNEYS

228. SIGNATURE OF SPLEENS

229. SIGNATURE OF PANCREASES

230. SIGNATURE OF GALLBLADDERS

231. SIGNATURE OF LIVERS

232. SIGNATURE OF STOMACHS

233. SIGNATURE OF LUNGS

234. SIGNATURE OF KIDNEYS

235. SIGNATURE OF SPLEENS

236. SIGNATURE OF PANCREASES

237. SIGNATURE OF GALLBLADDERS

238. SIGNATURE OF LIVERS

239. SIGNATURE OF STOMACHS

240. SIGNATURE OF LUNGS

241. SIGNATURE OF KIDNEYS

242. SIGNATURE OF SPLEENS

243. SIGNATURE OF PANCREASES

244. SIGNATURE OF GALLBLADDERS

245. SIGNATURE OF LIVERS

246. SIGNATURE OF STOMACHS

247. SIGNATURE OF LUNGS

248. SIGNATURE OF KIDNEYS

249. SIGNATURE OF SPLEENS

250. SIGNATURE OF PANCREASES

251. SIGNATURE OF GALLBLADDERS

252. SIGNATURE OF LIVERS

253. SIGNATURE OF STOMACHS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00854
875 CERTIFICATE OF DEATH Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Matyland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 10 days		CITY (If outside corporate limits, write RURAL and give nearest town) Rockville		26	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital 1				STREET ADDRESS (If rural give location) 1214 Crawford Street			
3. NAME OF DECEASED: (First) (Middle) (Last) Jack Lee VAN SCYOC				4. DATE (Month) (Day) (Year) OF DEATH: January 11 19 56			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single	8. DATE OF BIRTH: 1-1-56		9. AGE last birthday yrs. 18		IF UNDER 1 YEAR Months 10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Charles D. VAN SCYOC				14. MOTHER'S MAIDEN NAME: Edna LAYTON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY No. None		17. INFORMANT & ADDRESS: Father Charles D. VAN SCYOC Same as above			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) Cardiac arrest (during surgery)		
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. INTESTINAL OBSTRUCTION	12 hrs
--	---------------

19A. DATE OF OPERATION: 3 11 Jan '56	19B. MAJOR FINDINGS OF OPERATION INTESTINAL OBSTRUCTION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	---	---

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	---

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **1 Jan., 1956**, to **11 Jan., 1956** that I last saw the deceased alive on **11 Jan., 1956**, and that death occurred at **3:13 A.** from the causes and on the date stated above.

SIGNATURE H. A. PEARSON	ADDRESS U. S. Naval Hospital, NNMC, Bethesda, Maryland	DATE SIGNED
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 17 Jan 1956	NAME OF CEMETERY OR CREMATORY Illinois

DATE REC'D BY LOCAL REGISTRAR 11 Jan 1956	REGISTRAR'S SIGNATURE Mary E. Parrelly	24. FUNERAL DIRECTOR R. A. Pamphrey, Funeral Home	ADDRESS 7557 Wisconsin Avenue, Bethesda, Md.
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 16 1936

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223

735

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Wash., D.C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park,</u>	LENGTH OF STAY (in this place) <u>1-16-56 to 1-18-56</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	<u>47X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75 Washington Sanitarium or Hospital</u>		STREET ADDRESS (If rural give location) <u>1717 E. Capitol Street</u>	✓
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>John</u>	(Middle) <u>Nicholis</u>	(Last) <u>Vasiliadis</u>	(Date) <u>January 18,</u> (Year) <u>1956</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>10-18-1893</u>
9. AGE last birthday <u>62</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Constantinople</u>	
11. BIRTHPLACE (State or foreign country): <u>Constantinople</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME: <u>Nicholas Vasiliadis</u>		14. MOTHER'S MAIDEN NAME: <u>Asposia Agapiou</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <u>Mrs. Beulah M. Vasiliadis</u> <u>1717 E. Capitol St., Wash., D.C.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
490X IMMEDIATE CAUSE (A) <u>Cornary Thrombosis</u>			<u>Sudden</u>
ANTECEDENT CAUSE (B) <u>Bilat. Pneumonia</u>			<u>3 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Cornary Thrombosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>			19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
		21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>6/4</u> , 19 <u>56</u> , to <u>1/18/56</u> , that I last saw the deceased alive on <u>1/18/56</u> , and that death occurred at <u>10:23</u> M, from the causes and on the date stated above.			
SIGNATURE <u>J. I. House</u>		DATE SIGNED <u>1/18/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Prince Georges Co Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 19-1956</u>		REGISTRAR'S SIGNATURE <u>J. I. House</u>	
24. FUNERAL DIRECTOR <u>S. H. House Co.</u>		ADDRESS <u>2901-14 20th St NW</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

1. IN THE COUNTY OF ... STATE OF ...

2. DECEASED ...

3. DECEASED ...

4. DECEASED ...

5. DECEASED ...

6. DECEASED ...

7. DECEASED ...

8. DECEASED ...

9. DECEASED ...

10. DECEASED ...

11. DECEASED ...

12. DECEASED ...

BUREAU V. S.

JAN 23 1900

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00856

876

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	LENGTH OF STAY (in this place) <i>5 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>921 Philadelphia Avenue</i>		STREET ADDRESS (If rural give location) <i>921 Philadelphia Avenue</i>	
3. NAME OF DECEASED: (Type or Print) <i>LELIA</i> (First) <i>WEBB</i> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <i>Jan. 29 1956</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Dec. 31, 1876</i>
9. AGE last birthday: <i>79</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>at home</i>	11. BIRTHPLACE (State or foreign country): <i>Knox County, Illinois</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME: <i>Andrew Lowman</i>	
14. MOTHER'S MAIDEN NAME: <i>Francis Agnew</i>		15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <i>Lester P. Webb, 921 Philadelphia Ave S Md</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <i>442x</i>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION: <i>0</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>0</i> M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1960</i> , to <i>1/29/56</i> , that I last saw the deceased alive on <i>1/27/56</i> , and that death occurred at <i>9:50 P</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Dr. H. J. Holahan</i>		DATE SIGNED <i>1/29/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Transit Burial</i>		DATE THEREOF <i>Feb. 1, 1956</i>	
NAME OF CEMETERY OR CREMATORY <i>Lynnhurst Cemetery</i>		LOCATION (City, town, or county) (State) <i>Knoxville, Tennessee</i>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS <i>James J. Walters, 254 Carroll St NW, DC</i>	

BUREAU V. S.

FEB 2 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

877

CERTIFICATE OF DEATH

Reg. Dist. No. 215

00857

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda Rural</u>		5 days		OR TOWN <u>Cheverly</u>		16-38-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>6001 Euclid Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Glenn Raymond WEGER				Jan 23 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Single	7 Jul 50	5 yr 6mo yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						Maryland	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Raymond A. WEGER				Clare PENN			
15. WAS DECEASED EVER IN U.S. ARMOED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
				-----		Raymond A. Weger, Same as #2	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
193X IMMEDIATE CAUSE (A) <u>medulloblastoma</u>						30 mos.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Inanition</u>						2 mos.	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
12/14/53		medulloblastoma					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>18 Jan</u> , 1956, to <u>23 Jan</u> , 1956, that I last saw the deceased <u>alive on 23 Jan</u> , 1956, and that death occurred at <u>12:20 P.M.</u> , from the causes and on the date stated above.							
<u>R.W. Mackie</u> R.W. MACKIE, CDR MC USN				ADDRESS DATE SIGNED M. D. U.S. NAVAL HOSPITAL BETHESDA MD			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		26 Jan 1956		Arlington National		Arlington Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		Washington, D.C.	
23 Jan 1956		<u>Mary E. Russell</u>		LEE FUNERAL HOME 4th & Massachusetts,			

BUREAU V. S.

JAN 27 1956

RECEIVED

Reg. Dist. No. 214

Reg. Dist. No. 214

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 30 1936

RECEIVED

879

Item 9, Film 102 2-7-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Bethesda</u>		<u>10 days</u>		<u>Cherry Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<u>Suburban</u>				<u>4700 Bradley Blvd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>Adelaide Reardon Wells</u>				<u>Jan. 25 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Feb. 9, 1888</u>	<u>66</u> yrs.	<u>11</u> Months	<u>16</u> Days	<u>16</u> Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State of foreign country):	
<u>Housewife</u>						<u>Baltimore, Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>George Reardon</u>				<u>Emilie Fant</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Apt. 4c-208 East 70th St. Mary P. Bruns- New York City, New York</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)							
<u>491X Respiratory Failure</u>							<u>Few hours</u>
ANTECEDENT CAUSE (B)							
<u>Confluent Bronchopneumonia</u>							<u>Few days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Anesthesia & Surgical Shock</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>3 24 Jan. '56</u>				<u>Carcinoma Spleen Flexure Colon</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 26</u> , 19 <u>56</u> to <u>Jan 25</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Jan 26</u> , 19 <u>56</u> , and that death occurred at <u>8:55</u> AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>John W. Ball</u>				<u>7736 Arlington Rd Bethesda Md</u>		<u>1/25/56</u>	
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/27/1956</u>		<u>Arlington National</u>		<u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>1-31-56</u>		<u>Beau M. Thompson</u>		<u>Robert A. Humphrey</u>		<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Form with multiple sections and fields, including checkboxes and text areas. The form is oriented horizontally but contains vertical text labels for various sections. The text is mostly illegible due to the quality of the scan and the orientation of the document.

RECEIVED

FEB 3 1956

BUREAU V. 8

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

880

CERTIFICATE OF DEATH

00860

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Silver Spring</u>				TOWN <u>Silver Spring</u>		56	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Greens Nursing Home</u>				STREET ADDRESS (If rural give location)			
<u>90</u> <u>Colesville Road, Silver Spg.</u>				<u>14428</u> <u>Colesville Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Choulette</u> (Middle) <u>S</u> (Last) <u>Wenner</u>				(Month) <u>Jan.</u> (Day) <u>8</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>single</u>	<u>Feb. 3, 1870</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Buyer-</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Garfinckels</u>		11. BIRTHPLACE (State or foreign country) <u>Near Lovettsville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Jonathan A. Wenner</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Alder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-20-0198</u>		17. INFORMANT & ADDRESS <u>14428 Colesville Rd.</u>			
				<u>Miss Rachel M. Crown</u> <u>S.S.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.2 IMMEDIATE CAUSE (A) <u>A p. phlegia, thrombosis</u>						<u>2 wks.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis</u>						<u>3 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 6</u> , 19 <u>55</u> , to <u>Jan</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>56</u> , and that death occurred at <u>12:25</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Ad. Bonjant</u>				ADDRESS (Street, city, town, state) <u>5m. D. Spring, Md.</u>		DATE SIGNED <u>1/8/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>January 11, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Francis Potter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>2901 14th St. N. W. Washington, D.C.</u>			
DATE <u>1-10-56</u>							

CERTIFICATE OF DEATH

980

REG. FILE NO.

1. DEATH NUMBER (NUMBER OF DECEASED)

2. PLACE OF DEATH

3. MARRIAGE

4. MONTGOMERY

5. SILVER SPRING

6. NAME OF DECEASED

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. PLACE OF BIRTH

11. DATE OF BIRTH

12. SEX OF DECEASED

13. OCCUPATION

14. EDUCATION

15. RELIGION

16. MARITAL STATUS

17. DATE OF MARRIAGE

18. NAME OF SPOUSE

19. NAME OF CHILDREN

20. NAME OF GRANDCHILDREN

BUREAU V. S.

JAN 12 1962

RECEIVED

SMITHSONIAN INSTITUTION

This is a copy of the original record of the death of the deceased, as recorded in the official records of the State Department of Health, Baltimore, Maryland. It is not to be used for legal purposes, but for informational purposes only. The original record is the only one to be used for legal purposes.

881

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY MONTGOMERY	MARYLAND	STATE MARYLAND	COUNTY MONTGOMERY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN SILVER SPRING	LENGTH OF STAY (in this place) 46 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8718 FIRST AVENUE		STREET ADDRESS (If rural give location) 8718 FIRST AVENUE	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) RACHEL	(Middle) COOKE	(Last) WHITACRE	
(Type or Print)		JANUARY 9 1956	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: DEC. 27, 1879
9. AGE last birthday: 76 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME	
11. BIRTHPLACE (State or foreign country): GAITHERSBURG, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: NATHAN P. COOKE		14. MOTHER'S MAIDEN NAME: CATHERINE S. COOPER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. None	
17. INFORMANT & ADDRESS: Miss Pauline E. Whitacre, 8718 1st Ave., SS. Md.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 420.0		Sudden	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/16 , 19 50 to 1/9 , 19 56 , that I last saw the deceased alive on 1/9 , 19 56 , and that death occurred at 8 P.M. from the causes and on the date stated above.			
SIGNATURE Marion Bausch		DATE SIGNED 1/9/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF JAN. 12, 1956	
NAME OF CEMETERY OR CREMATORY FOREST OAK CEMETERY		LOCATION (City, town, or county) (State) GAITHERSBURG, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 1-11-56		24. FUNERAL DIRECTOR Warner E. Pumphrey ADDRESS SILVER SPRING, MD.	

MARGIN RESERVED FOR BINDING

TO WHOM IT MAY CONCERN

BUREAU V. S.

JAN 12 1956

RECEIVED

882

00862
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 213

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockville</u>	LENGTH OF STAY (in this place) <u>3 yrs.</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. 1 South Glen Rd</u>		STREET ADDRESS (If rural, give location) <u>Rt. 1. South Glen Road</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>EDWARD</u>	(Middle) <u>B</u>	(Last) <u>WILBER</u>	(Month) <u>Jan.</u> (Day) <u>2</u> (Year) <u>1956</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9-24-1902</u>
9. AGE last birthday: <u>53</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>8</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Asst. Sec. State</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Government</u>	
11. BIRTHPLACE (State or foreign country): <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Thomas Cornelius Wilber</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Meade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>	
(If Yes, give war or dates of service) <u>No</u>		17. INFORMANT & ADDRESS: <u>Son, Edward B. Wilber Jr. South Glen Rd Rockville</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Cardiac Failure -</u>		<u>5 min.</u>
Antecedent cause(s) (b) <u>Coronary occlusion -</u>		<u>5 min.</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>John B. Bell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/3/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>1-5-1956</u>	NAME OF CEMETERY OR CREMATORY: <u>Parklawn</u>
LOCATION (City, town, or county) (State): <u>Rockville Maryland</u>	24. FUNERAL DIRECTOR ADDRESS: <u>Bethesda, Md.</u>	
DATE REC'D BY LOCAL REG. <u>1/6/56</u>	REGISTRAR'S SIGNATURE: <u>Laurel H. Beagles</u>	24. FUNERAL DIRECTOR ADDRESS: <u>Robert A. Humphrey</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 9 1950

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

883

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00863

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: SILVER SPRING 406 MANFIELD RD COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE SAME COUNTY Mont	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 56 TOWN SILVER SPRING		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING 56	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS (If rural give location) 406 MANFIELD Rd. SILVER SPRING	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) MARION G. WISEMAN		4. DATE (Month) (Day) (Year) OF DEATH: JAN. 6 1956	
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: JULY 28, 1916
9. AGE last birthday 37 yrs.		10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY: —	
11. BIRTHPLACE (State or foreign country): WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME: SAMUEL ZUKERMAN		14. MOTHER'S M maiden NAME: LENA LEANER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT & ADDRESS: LEON WISEMAN - 406 MANFIELD RD SILVER SPRING MD			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
170X IMMEDIATE CAUSE		(A) Carcinoma of breast with metastases	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec 23, 1953 to Jan 6, 1956, that I last saw the deceased alive on Jan 1, 1956, and that death occurred at 4:30 P.M. from the causes and on the date stated above. SIGNATURE <i>Blanche H. H. H.</i> ADDRESS M.D. 8641 Cleveland Rd Silver Spring, Md DATE SIGNED Jan 6, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec 8/1956	
NAME OF CEMETERY OR CREMATORY Beth Shalom		LOCATION (City, town, or county) (State) Capt Heights Md	
DATE REC'D BY LOCAL REGISTRAR 1-10-56		REGISTRAR'S SIGNATURE Frances Teller	
24. FUNERAL DIRECTOR B. J. J. J. J.		ADDRESS H. H. H. H.	

BUREAU V. S.

JAN 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

884

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montg</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Montg</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR TOWN
<i>x</i> TOWN	<i>Days</i>	<i>Silver Spring</i>	<i>56</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		<i>7020-Fairview Rd.</i>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)		OF DEATH:	
<i>Mary</i>	<i>Boykin</i>	<i>1</i>	<i>26</i>
			<i>1956</i>
5. SEX:	6. COLOR OR RACE:	7. SINGLE MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:
<i>F</i>	<i>W</i>		<i>JAN 10, 1868</i>
			<i>88</i> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<i>Housewife</i>		<i>-</i>	<i>Cleaton, N.C.</i>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Robinson Fennell Boykin</i>		<i>Ann Hobbs</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
		<i>John F Wolfe - 7020-Fairview Rd.</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <i>Congestive left heart failure</i>		<i>10 days</i>
ANTECEDENT CAUSE (B) <i>Hypertensive heart disease</i>		<i>10 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<i>4</i>
(C) <i>Coronary atherosclerosis</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 3, 1956</i> to <i>Jan 26, 1956</i> , that I last saw the deceased alive on <i>Jan 26, 1956</i> , and that death occurred at <i>11:30 P.M.</i> , from the causes and on the date stated above.					
SIGNATURE <i>W. J. Sperry M.D.</i>		ADDRESS <i>4601-16th St</i>		DATE SIGNED <i>1/26/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
		<i>1/30/56</i>		<i>Cleaton Cem.</i>	
				<i>Cleaton, N.C.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR'S ADDRESS	
<i>1-27-56</i>		<i>James Potter</i>		<i>The S. N. Miller Co. 2805 1st St. Wash, D.C.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 30 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

712

00865

Reg. Dist.

No. 213

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Rockville</u>		<u>6 mo</u>		TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>818 Crothers Lane</u>				STREET ADDRESS (If rural, give location) <u>818 Crothers Lane</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Fredrick James</u> (Middle) <u>Woolfitt</u> (Last) <u>Woolfitt</u>				(Month) <u>Jan</u> (Day) <u>23</u> (Year) <u>1956</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Oct 20 1920</u>	
9. AGE last birthday: <u>35</u> yrs.		IF UNDER 1 YEAR: <u>3</u> Months <u>3</u> Days		IF UNDER 24 HRS. <u>3</u> Hours <u>3</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>art accountant</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>P.O. Apt.</u>		11. BIRTHPLACE (State or foreign country): <u>Mich</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>Emerson Lee Woolfitt</u>				14. MOTHER'S MAIDEN NAME: <u>Ethel M. Bachstrom</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>YES</u> (If Yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Jane Woolfitt (wife) same as Num 2</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Coronary occlusion</u>							<u>1 hr.</u>
DUE TO							
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>							
DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Donald Broichant</u>		M. D. <u>Robert A. Humphrey</u>		DATE SIGNED <u>1-23-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-26-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REG. <u>1/25/56</u>		REGISTRAR'S SIGNATURE <u>Lamell H. Bragley</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

RECEIVED

JAN 27 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00866

885

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>43 1/4 hrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u>		<u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>824 Lakeside ST. N.W.</u>		✓	
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>Elsie</u>		(Middle) <u>J.</u>		(Last) <u>Yarboro</u>			
(Type or Print)				OF DEATH: <u>1-18-1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>12/30/00</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>house wife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Asheville North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>John Carland</u>				14. MOTHER'S MAIDEN NAME: <u>Mary A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Edward Ward - Son-in-law</u> <u>3102 Blueford Rd Kensington Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cholera due to Liver Metastasis from (3 days)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>			
ANTECEDENT CAUSE (B) <u>Carcinoma of Breast (Rt.)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 10, 1955</u> , to <u>Jan. 18, 1956</u> that I last saw the deceased alive on <u>Jan. 16, 1956</u> and that death occurred at <u>2:16 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Samuel Allen</u>		M. D. <u>Kensington Md.</u>		DATE SIGNED <u>Jan 18, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 21, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/23/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR ADDRESS <u>F. Gasch's Sons Hyattsville, Maryland.</u>			

RECEIVED

JAN 25 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>3 hours</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		STREET ADDRESS (If rural give location) <u>4865 Battery Lane</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Mary</u>	(Middle) <u>Louise</u>	(Last) <u>York</u>	OF DEATH: <u>Jan 30 1956</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, <u>DIVORCED</u>	8. DATE OF BIRTH: <u>11-21-1909</u>
		9. AGE last birthday <u>46</u> yrs.	IF UNDER 1 YEAR: Months <u>2</u> Days <u>9</u> Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Administrative Asst N.I.H.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u></u>	
11. BIRTHPLACE (State or foreign country): <u>Rome, Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Isham Rhone Walker</u>		14. MOTHER'S MAIDEN NAME: <u>Zollie Johnson Hunt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Sister Clara Walker</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Massive Subarachnoid Hemorrhage</u>		<u>3 hours</u>
ANTECEDENT CAUSE (S) (B) <u>Ruptured Congenital Aneurysm</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Right carotid artery</u>		<u>2 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>1/30 10:30 PM</u>	
22. I hereby certify that I attended the deceased from <u>8 PM</u> , 19 <u>56</u> , to <u>1:30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/30</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.					
SIGNATURE <u>Charles E. Engeling M.D.</u>		ADDRESS <u>4928 St Elmo Ave</u>		DATE SIGNED <u>1/30/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>2-1-56</u>		NAME OF CEMETERY OR CREMATORY <u>Riverside Memorial Pk</u>	
				LOCATION (City, town, or county) (State) <u>Jacksonville Florida</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/4/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>	
				ADDRESS <u>Bethesda, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 6 19

RECEIVED

736
CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Wash. D.C.</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>TAKOMA PARK</u>				OR TOWN <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San. + Hospital</u>				STREET ADDRESS (If rural give location) <u>918 Farragut Street</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Maurice (none) Yockelson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>January 15 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>March 15, 1895</u>	
9. AGE last birthday <u>60</u> yrs.		IF UNDER 15 MONTHS		IF UNDER 24 HRS. DAYS		HOURS MIN.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Red's Neon Sign Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME: <u>Abramam Yockelson</u>				14. MOTHER'S MAIDEN NAME: <u>Rebecca Goldstein</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Acute coronary insufficiency</u>		<u>3 hours</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Coronary Thrombosis with</u>		<u>96 hours</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>myocardial infarction</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 12, 1956, to Jan. 15, 1956, that I last saw the deceased alive on January 15, 1956, and that death occurred at 3:55 PM, from the causes and on the date stated above.

SIGNATURE <u>Claron H. Kraum</u>		ADDRESS <u>M.D. 8237 Georgia Ave - Silver Spring Md</u>		DATE SIGNED <u>Jan 15 '56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/15/56</u>		NAME OF CEMETERY OR CREMATORY <u>Beth Shalom</u>	
LOCATION (City, town, or county) <u>Wash. DC</u>		(State)			
DATE REC'D BY LOCAL REGISTRAR <u>Jan-15-1956</u>		REGISTRAR'S SIGNATURE <u>William Noddle</u>		24. FUNERAL DIRECTOR <u>B. Damsky & Son Wash. DC</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 17 1956

RECEIVED

00869

887

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montg</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Gaithersburg</u>		<u>23 yrs</u>		TOWN <u>Gaithersburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>14 E. Diamond Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Louis</u> (Middle) <u>E. McComas</u> (Last) <u>Younkins</u>				(Month) <u>Jan</u> (Day) <u>31</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Apr 30-1887</u>	<u>68</u> yrs.	Months <u>7</u>	Days <u>1</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired U S A Institute of Health.</u>		<u>Frederick Co. Md.</u>		<u>U S A</u>		<u>U S A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John W. Younkings</u>				<u>Elizabeth Reeder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>L. Renold Ypunkins. Gaithersburg</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Intra Cranial Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio sclerosis - Genl.</u>				<u>Years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>1 Renoidal left ventricle</u>				<u>Two years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 15, 1956</u> , to <u>Jan 31, 1956</u> , that I last saw the deceased alive on <u>Jan 15, 1956</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Jack Schumacher</u>		M.D. <u>Gaithersburg, Md</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>2-1-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-2-56</u>		<u>Middletown Cemetery</u>		<u>Middletown Md,</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb 2/56</u>		<u>Abraham G. Coale</u>		<u>ERNEST C. GARTNER.</u>		<u>Gaithersburg/ Md,</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

